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DEBORAH E. ZUCKERMAN, M.D.
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IOANNIS P. GLAVAS, M.D.
Oculoplastics

RODNEY IMMERMAN, O.D.
Low Vision Specialist

ROBERT D. JOHNSON, O.D.
Contact Lens Specialist

LISA PILLERI, O.D.
General Optometry

ALEC J. SMAIL, O.D.
Contact Lens Specialist

EYE ASSOCIATES, P.C.
P&D Eye Associates, LLC
Patient Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth_____

I authorize _____ (Name of Provider)

_____ (Address)

_____

To release the following health information:

_____ Medical Records _____Other, Please specify: _____

To: _____ (Name of recipient)

_____ (Address of recipient)

_____

Reason for Request? _____ Insurance 2nd Opinion _____ Moving_____ Other: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extend that the covered entity has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy officer at the covered entity.

Signed by: _____ _____

(Signature of patient/legal guardian) (Relationship to Patient)

_____ _____

(Print Patient's name) (Print Name of Legal Guardian)

Date _____

Records can take two weeks to prepare: I would like to _____ Pick up _____ Mail

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