SouthEast Eye Physicians & Surgeons

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Patient:

NAME: LAST FIRST MI D.O.B

STREET ADDRESS

CITY STATE ZIP PHONE

2. Authorize records released from:

NAME

STREET ADDRESS

CITY STATE ZIP PHONE

3. Records released to:
SouthEast Eye, S.C.
Raffi Karapetian, D.O., V. Stephen Slana, M.D
6125 Greenbay Rd. Suite 800
Kenosha, WI 53142

4. Type or extent of information to be released: (CIRCLE all applicable categories)

Medical History, Examination, Reports
Treatment or tests
X-Ray reports
Laboratory Reports
Prescriptions
Surgical Reports
Hospital Records including Reports
Entire Records
Consultations
Other

5. Purpose or need for release: _____

6. This authorization will remain in effect from _____ until _____.

7. I UNDERSTAND THE FOLLOWING:

· I may inspect or copy the protected health information to be used or disclosed.
· I may revoke this authorization in writing by contacting your office.
· Information used or disclosed to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
· I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization. (Except to the extent that the authorization is for research-related treatment).
· I understand that you may receive compensation from a third party for the use or disclosure of my information.

Patient Name **Signature** **Date**