

Austin Village Eyecare
1013 Chestnut Lane; Suite 210
Matthews NC 28104

Patient Information: Print name: _____ Date of Birth: _____

SS#: _____ Maiden or prior name: _____

Please release my healthcare information from:
Name of Facility/Provider

Please release my healthcare information to
Name Designated Recipient

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

Phone Number: _____

Phone Number: _____

Information to be released

- The most recent 2 years of pertinent information (chart notes, and special tests)
- All medical records
- Specific information (please specify)

Purpose for which disclosure is being made:

- Sharing with other health care providers
- Personal use
- Legal investigation
- I am transferring my care to a new health care provider
- Other:

My Rights:

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature _____ Date _____
(Patient, Guardian, Authorized Representative)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED