

SNEED EYE ASSOCIATES

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____,

authorize & request:

to furnish to:

Specify Practice/Facility or Physician Name

Specify name of recipient

my personal health information as indicated below:

- Medical Records, including diagnostic & radiological tests
- Billing Records
- Other _____

Information disclosed as requested in this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by the federal HIPAA rule.

Signature of Patient or Patient's Authorized Representative

Date

Representative's Name: _____

Representative's Authority: _____