

**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: \_\_\_\_\_