OPTHALMOLOGY CENTER OF BREVARD, LP dba
ASC OF BREVARD

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name	Date of Birth	Telephone

ASC CHART# _____

Permission to send Medical Records to:

Name _____

Address _____

City/State _____

Telephone _____

I authorize this information to be faxed or emailed to: _____

For Healthcare Covering the Period(s) All, or From:_____To:_____

I understand that specific information to be released may include any illness or injury, medical history, consultation, prescription ortreatment, and/or copies of all medical records, including those provided by other Physicians or medical providers, including testing, photography, lab results, prescriptions, operative reports, and letters. This information may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

Unless otherwise indicated, this authorization will expire 12 months from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may be a fee for preparing and furnishing this information.

Signature of Patient or Legal Representative	Relationship to Patient	Date

Driver's License# If records picked up	Staff Signature	Date