NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE
4313 NW 8th Avenue • GAINESVILLE, FLORIDA 32605
(352) 373-4300 1(800)435-3937

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Who has your information?

Physician/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Who would you like to receive your information?

Physician/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure

☐ Continued / Transfer of Care ☐ Personal ☐ Other: _____

What information would you like disclosed?

☐ Complete health record(s)
☐ History & Physical Exam
☐ Consultation Reports
☐ X-ray/Scan Reports
☐ Photographs, Videotapes, Digital or Other Images
☐ Laboratory Tests
☐ Progress Notes
☐ Ascan & Keratometry
☐ IOL Model & Power
☐ MR & Keratometry before and after Lasik / RK / Cataract Sx
☐ Discharge Summary
☐ Other (Please Specify): _____

Covering the Period(s) of Health Care:

☐ Complete Patient History
☐ From (date): _____ to _____

I understand that this may include information related to: Acquired Immunodeficiency Syndrome (AIDS), Behavioral Health Services/Psychiatric Care**,** Human Immunodeficiency Virus (HIV), or Treatment for Alcohol and/or Drug Abuse

I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken. Unless otherwise revoked, this authorization will expire on the following day, event or condition: _____

I hereby release North Florida Cataract Specialists and Vision Care from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by me.

_____ _____ _____

Patient/Legal Representative Signature ***Witness*** ***Date***