AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

The undersigned hereby authorizes the release of medical information as follows:

Patient Name ____
First Middle Last

____
Address City, State, Zip

____
Birth date SSN Phone

I authorize ____
Name Phone #/Fax #

____
Address

To release information regarding my medical care and treatment to:
Ophthalmic Surgeons and Consultants of Ohio, Inc. and/or
Dr. ______________________________
262 Neil Ave, Suite 430, Columbus, OH. 43215

Information to be released:

- All care and treatment records

Include the following:

- Operative Reports
- Allergy Records
- Office Notes
- Lab Reports
- Visual Fields
- Other **(specify)**

Special Note: I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRI DISORDERS AND TREATMENT, AIDS and/or HIV TESTING and/or OTHER SEXUALLY TRANSMITTED DISEASES. I specifically consent to release and disclosure of this information, including transmission of my records via a facsimile (fax) machine. Subsequent transfer of my medical records or disclosure of their content is prohibited without my specific consent.

____ ______________
Signature of Patient or Authorized Representative Date

____
Relationship or status if signed by anyone other than the patient

This authorization expires 90 days after the date signed