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| --- | --- |
| Macintosh HD:Users:jessicahildebrand:Desktop:HEC_LogoVert_Print_Grayscale_LightBG.jpg | Harman Eye CenterHarman Eye Center of AmherstHarman Eye Center of AppomattoxHarman Eye Center of DanvilleHarman Eye Center of LovingstonHarman Eye Center of LynchburgHarman Eye Center at WyndhurstSurgery Center of Central Virginia |

P.O. Box 1290 | Forest, VA 24551

Phone: 434-385-5600 | Fax: 434-616-2313 | | www.Harmaneye.com

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |
| --- | --- |
| Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release healthcare information of the patient named above to: |  Harman Eye Center P.O. Box 1290 Forest, VA 24551 |
|  |  Fax: 434-616-2313 |

This request and authorization applies to:

[List here]

[List here]

[Additional information]

[List here]

I understand that I have the right to access my medical records in accordance with the law and the policies of Harman Eye Center. I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date indicated below. Please note that information disclosed pursuant to this request is no longer under the control of Harman Eye Center and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

|  |  |  |
| --- | --- | --- |
| Patient Signature: |  | Date signed: [Date] |
| Witness Signature: |  | Date signed: [Date] |
| Patient’s Legal Representative: |  | Date signed: [Date] |