EAST COAST RETINA, PA

PROTECTED HEALTH INFORMATION RELEASE

Full Name: _____ DOB: _____
SS#: _____ PHONE: _____

This will authorize _____ to disclose my protected health information, as described below.

_____

_____

_____

_____ Complete copy of medical records.
_____ Specific information only (If applicable, no other information may be included in Authorization).
_____ Other (describe).

_____

Dates of care: _____ to _____.

- I understand that I may inspect or copy the protected health information described by this authorization
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

DATE: _____ _____
Signature of individual or representative

_____
Witness signature

EXPIRATION DATE: This authorization will expire on _____. (If no date is stated, expiration is twelve months from the date it was signed.

8609 Montague Lane • Myrtle Beach, South Carolina 29588
Office: 843-215-3363 • Fax: 843-215-7201