Seidenberg Protzko Eye Associates
HIPAA Compliant Authorization for the Release of Patient Information

I authorize Seidenberg Protzko Eye Associates to release the protected health information of:

Patient Name: _____

Date of Birth: _____ Phone #: _____

Street Address: _____

City, State, Zip: _____

The information is to be released to:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

The information I wish to have released is (include dates of service):

_____

The purpose or need for this disclosure is: _____

1. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
2. I understand that if my records contain documentation of alcohol abuse, drug abuse, psychiatric conditions and/or communicable diseases, this information will be released as part of my record.
3. I understand that if the party receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
4. I understand that I may revoke this authorization in writing at any time, but the revocation will not apply to the information that has already been released.
5. I understand that there may be a charge for obtaining the requested information.
6. I understand that this authorization will expire one year from the date it is signed.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative

_____ _____
Signature of Witness Date

2023 Pulaski Highway, Havre de Grace, MD 21078
Phone: 410-939-6477 Fax: 410-939-6555