

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

*I authorize the release of the protected health information of:*

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

The information is to be released from:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

*The information is to be released to:*

Seidenberg Protzko Eye Associates  
2023 Pulaski Highway  
Havre de Grace, MD 21078  
Phone #: 410-939-6477 Fax #: 410-939-6555

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