AUTHORIZATION FOR RELEASE OF INFORMATION

Retina Specialists
of Alabama LLC

I, ______________________________ hereby authorize Retina Specialists of Alabama, LLC to use and/or disclosure of my protected health information to ______________________________________.

I understand that protected health information used and/or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

1. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):
   - ☐ Patient Info Card
   - ☐ Insurance Forms/Cards
   - ☐ Photos
   - ☐ FA Films/Digital
   - ☐ Consent to Treatment
   - ☐ Patient Summary Card (From __________ date to __________ date)
   - ☐ History and Physical (From __________ date to __________ date)
   - ☐ Amsler Grid (From ________________ physician's name)
   - ☐ Patient Account Statement/Billing Records
   - ☐ Dictated Notes - List Dates ______________________________
   - ☐ Handwritten Notes - List Dates ______________________________
   - ☐ Entire Record
   - ☐ Other ____

2. The following is the purpose(s) of the use and/or disclosure of my protected health information described above:

   ____

   or ☐ At the request of the individual.

3. I understand that Retina Specialists will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of my protected health information unless an applicable legal exception applies.

4. I understand that this Authorization is voluntary, and I have the right to refuse to sign this Authorization and to receive a copy of the signed Authorization upon request. Retina Specialists may not refuse to provide health care treatment to me if I do not sign this Authorization, unless either of the following applies:

   ☐ My treatment is related to research and the use and/or disclosure is related to such research; or
   ☐ My treatment is solely for the purpose of creating protected health information for disclosure to ______________________________________.

5. I understand that upon my request I may access and copy the protected health information described on this Authorization. I understand that my protected health information may include information concerning sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency syndrome (HIV), behavioral and mental health services, and treatment for drug and alcohol abuse.

6. I understand that I may revoke this Authorization in writing at any time by sending my written revocation to the Privacy Officer at 1201 11th Avenue South, Suite 300, Birmingham, Alabama 35205. I understand that any revocation will not affect any actions taken by Retina Specialists prior to receipt of my revocation. Unless otherwise revoked, this Authorization will expire on ____(date, event, or condition). If I fail to specify an expiration date, event or condition, this Authorization will expire in one (1) year.

7. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

Patient or Personal Representative (This Authorization MUST be completed before signing).

______________________________ ______________________________
Signature Printed Name

Date:____________________

If by patient's representative, describe relationship to the patient and authority to act on behalf of patient: ____________________

____.