MANNING, ROMMEL & THODE ASSOCIATES

MEDICAL AND SURGICAL EYE CARE

FRANCIS J. MANNING, M.D. ♦ CATHERINE T. ROMMEL, M.D. ♦ ADAM R. THODE, M.D.

Authorization To Receive/Release Health Information

Patient Name_____ Date of Birth_____

Address_____ City/State/Zip_____

I hereby authorize the disclosure of my health Information FROM:

The following information from my medical record, Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress notes, etc.

_____

Name of Person/Organization Releasing Information

_____

Address City/State/Zip

_____

Phone Number/Fax Number

To release my Information TO:

_____

Name of Person/Organization Releasing Information

_____

Address City/State/Zip

_____

Phone Number/Fax Number

Information to be released:

___Complete Medical Record (***excluding*** Mental Health, Drug and Alcohol)

___Complete Medical Record

___Medical Records for specific Dates of Service (please list) from _____to_____

___Other (please list)_____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclose but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be projected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____

Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____

Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____By:_____ Via:_____