Barenburg Eye Associates, Inc.

100 Park Avenue
Baltimore, Maryland 21201
(410) 727-0285

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:	Patient Phone Number:
Patient Address:	Patient E-Mail Address:
Location of Clinical Records: (Please check one) ❍ Park ❍ Woodholme ❍ Garwyn ❍ Dundalk ❍ Ellicott City	

I authorize Barenburg Eye Associates, Inc. to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse, treatment, and information about mental health services] under all circumstances pertaining to my eye care.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to:

Ellen Gordon
100 Park Avenue
Baltimore, Maryland 21201

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

As applicable, we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

As applicable, we may send you a postal card reminding you to schedule an appointment, or to notify you that your eyewear is ready.

In all instances, Barenburg Eye Associates will show prudence and release only the minimum protected information necessary to a particular disclosure.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____