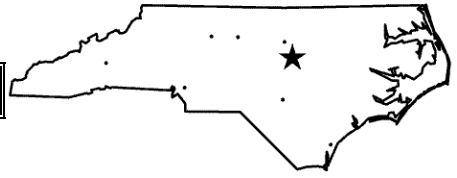


**NORTH CAROLINA RETINA**

**Authorization for Release of Information**



**Patient Information**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_

North Carolina Retina is authorized to release protected health information pertaining to the above named patient to entities listed below. Please **initial** each that is **authorized to receive information**.

Voice Mail/Answering Machine \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

**Description of information to be released** – please **initial** the following.

All info or  Financial/billing information or  Medical, incl. results from diagnostic tests

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do this by written notification. I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

**Acknowledgment of Receipt – Notice of Privacy Practices**

*A copy of the Notice of Privacy Practices from North Carolina Retina has been made available to me.*

Patient (please print) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If applicable, please complete the section below

Personal Representative (please print) \_\_\_\_\_

Personal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Authorization for Treatment / Financial Responsibility**

I hereby authorize the physicians and staff of North Carolina Retina to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physician during any and all visits to North Carolina Retina. I understand that I am financially responsible for all charges for services rendered to me by North Carolina Retina.

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

We were unable to obtain the acknowledgement for the following reason –

- An emergency existed and a signature was not possible.
  - Patient refused to sign.
  - Unable to communicate with patient.
  - Other \_\_\_\_\_
- Prepared by \_\_\_\_\_ (please initial)