Records Release Authori ation

Patient Name ____**Date of Birth**____/____/____

I authori e SightMD to disclose the follo ing health information choose ONE

- All of my health information

- My health information relating to the following treatment or condition:
____

- My health information covering the period from __________(date) to ___________(date)

- Other: ____

The abo e part ma disclose this health information to the follo ing recipient s

- Myself

Mailing Address: ____

____Fax #: _______________

- Other

Name or Title of Organization: ____

Address: ___________________________City: __________________State: ____Zip: _____

Phone #: ____________________Fax #: ___________________

Send b choose ONE MAIL FAX

M Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under f

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