SKOLNICK EYE INSTITUTE

641 University Blvd, Ste. 111
Jupiter, FL 33458
(561) 296-2010

Authorization for Use or Disclosure Of Health Information

Patient Name: _____ Patient's DOB: _____

Patient Address: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Description of the Information to be Used or Disclosed Including (If Applicable) the Dates of Service(s) Related to Such Information:

Complete Medical Record, including all tests and visual fields

Persons or Class of Persons Authorized to Make the Use or Disclosure of Authorized Information (location of records - doctor's name, address, phone, fax):

_____

_____

_____

Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made:

Craig A. Skolnick, M.D., Skolnick Eye Institute, 641 University Blvd, Ste 111, Jupiter, FL 33458 (561) 296-2010 – Fax (561) 296-2001

Authorized Information will be used and/or disclosed for the following purposes:

X At the request of the individual
__ Other (Please list each purpose of the use(s) or disclosure(s) in the space provided:

*I understand that if the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Signature Date