OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

210.223.5561
OphthalmologySA.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient full name | Date of birth | ID#

Patient's street address | City | State | ZIP

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by others, including health care providers. It may include medical, pharmacy, dental, vision, behavioral health, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information;
- I may be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- The information I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws;

I authorize Ophthalmology of San Antonio to disclose my individually identifiable health information to:

Name | Relationship | Phone

Patient's street address | City | State | ZIP

Name | Relationship | Phone

Patient's street address | City | State | ZIP

Signature of Patient/Representative | Date