OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

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OphthalmologySA.com

RECORDS RELEASE

Date: _____

To: _____

I hereby authorize you to release to:_____

_____

any information including ALL diagnoses and records of any treatment or examination rendered to me.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

Print or type name: _____

Signature: _____

SS#: _____

DOB: _____

Witness Signature: _____