Manchester Ophthalmology, LLC

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

- [] Release of all health information
- [] Release of all health information **excluding**
  - [] HIV Testing and Results
  - [] Alcohol or Drug Abuse Records
  - [] Psychiatric Records
- [] Release only specified health information as follows:

  _____
  _____

Person(s) Authorized to Disclose Information
Information above will be disclosed by:

_____
Name and Address of Person or Organization Information is Being Requested From

Person(s) to Whom Information May be Disclosed
Information described above may be disclosed to:

_____
Name and Address of Person or Organization Information to be Disclosed To

Patient Name: _____ **D.O.B.** _____
Please Print

***Signature*:** _____ ***Date*:** _____

*There may be a charge of $.45 per page for copying records

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For Office Use Only:
Date Copies: _____
Copied By: _____

Patient Account _____
Date Mailed/Picked up: _____