PROVIDENCE EYE & LASER SPECIALISTS

# Authorization for Release and/or Disclosure of Medical Information

Treatment, payment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

| Please **REQUEST** Medical Information **FROM**: | Please **SEND** Medical Information **TO**: |
|---|---|
| | Reza Michael Mozayeni, M.D. |
| Name of Health Care Provider | Name of Health Care Provider |
| | Providence Eye & Laser Specialists |
| **Name of Medical Office/Hospital** | Name of Medical Office/Hospital |
| | 3025 Springbank Lane, Suite 200 |
| Street Address | Street Address |
| | Charlotte, North Carolina 28226 |
| **City, State** and Zip Code | City, State and Zip Code |
| | Phone: (704) 540-9595 Fax (704) 540-9616 |

**I hereby authorize _____ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**
**Release and / or disclose records and information regarding:**

| **Name of Patient** (List Other Names Used) | | Medical Record Number | Date of Birth |
|---|---|---|---|
| | | | ( ) |
| Address | City | State Zip Code | Telephone Number |

**DURATION:** This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**REDISCLOSURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:**

**Check the box and initial which type of information is to be released and / or disclosed:**

☐ **Eye Records** (from initial visit to _____)

☐ **Information Regarding Specific Injury or Treatment** (from _____ to_____)

☐ **X-Ray (check one or both):** ☐ **Films** ☐ **Reports**

☐ **Laboratory Results**

☐ **Other (specify):**

**I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only:**

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

| Date: | **Signature of Patient or Patient's Representative** | Indicate Relationship (If signed by Other than Patient) |
|---|---|---|