

San Antonio Eye Center, P.A.

Dudley H. Harris, M.D.
Jason Ming Zhao, M.D.
David B. Abrams, M.D.
Sora Hahn-Navas, M.D.

Georgia Stephenson, M.D.
Sanford Roberts, M.D.
John Nicolau, M.D.
Aaron Erdmanczyk, O.D.

Eye of Horus:
Ancient Egyptian symbol for things
made more precious by having
been restored

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO S.A.E.C.

Today's Date: _____

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ (required) Social Security # _____

I authorize: Name: _____ Address: _____

City/State/Zip _____ Phone _____ Fax _____

For the purpose of: _____ (required)

to disclose the above name individual's health information to the following individual or organization:

San Antonio Eye Center, P.A. at 800 McCullough, San Antonio, Texas 78215

Please release the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Brief Summary of medical records | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Financial Records | <input type="checkbox"/> Visual Fields |
| <input type="checkbox"/> List of Allergies | <input type="checkbox"/> Operative Records | <input type="checkbox"/> Other diagnostic reports |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

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.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. In understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Dudley H. Harris, M.D., P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Debbie Payne at (210) 226-6169 ext. 221.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

www.saeeye.com

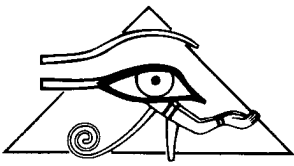
DOWNTOWN
800 McCullough
San Antonio, Texas 78215
(210) 226-6169
Fax: (210) 226-6383

SOUTHSIDE
2119 Commercial
San Antonio, Texas 78221
(210) 922-0604
Fax: (210) 922-0689

NORTHSIDE
14807 San Pedro Avenue
San Antonio, Texas 78232
(210) 495-2020
Fax: (210) 495-4500



Accredited by
**Accreditation Association
for Ambulatory
Health Care, Inc.**



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Name: _____ Address: _____

City/State/Zip _____ Phone _____ Fax _____

For the purpose of: _____ (required)

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