Pediatric Ophthalmology Associates, P.A.

William O. Young, MD

Pediatric Ophthalmology • Pediatric and Adult Strabismus

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

***Completed form and applicable fee must be received prior to processing***

I consent and authorize the following information to be released from the medical records of:

Patient Name Date of Birth

(Street address or P. O. Box)

(City/State/ZIP) (Phone)

**This information is to be released:**

| | | | |
|---|---|---|---|
| (circle one) | **William O. Young, MD** | (circle one) | _____ |
| **FROM** | **Pediatric Ophthalmology Associates** | **TO** | _____ |
| | **2519 Oakcrest Avenue** | | _____ |
| **TO** | **Greensboro, NC 27408** | **FROM** | _____ |
| | **336.271.2007 (F) 336.271.2904** | | _____ |
| | | | Phone/Fax |

**Please indicate information that is to be released:**

_____Complete File _____Most recent visit _____Operative/Lab reports

**Purpose of disclosure:**

_____Continued Patient Care
_____Transfer of Care
_____Insurance
_____Attorney/Legal
_____Personal Use
_____Other (specify)_____

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by these regulations.
I understand that I may revoke this authorization at any time by a written notice to the releasing entity. I further understand that any action taken on this authorization prior to the rescinded date may not be revoked. This authorization is valid for the period of time needed to fulfill its purpose for up to one year.

Signature of Patient or Parent/Guardian Relationship Date

**Complete only if information is to be released directly to patient:**
I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand that I should contact my physician regarding entries made in my medical record, to prevent my misunderstanding of the information that has been written in the record. I will not hold the party releasing information liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
Signature of Patient or Parent/Guardian: _____

**Office use only**

**Approved/Date _____Staff Initials_____**