



## Authorization to Release / Review Health Information

Our practice will not release your health information without your permission, except as provided in our Notice of Privacy Practices. This form means that you are giving permission for us to obtain, release, or disclose your information as described below:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### I hereby request a release of my health information from:

Practice Name / Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Please send the following information:

- History / Physical exam
- Laboratory results
- Health Record starting from the following date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Complete Health Record (all available dates)

### Please release and send my health information to:

#### Rutzen Eye Specialists

489 Ritchie Highway, Suite 200 Severna Park, MD 21146

Phone: 410-975-0090 Fax: 410-975-0089

### This information will be released for the following purposes:

- Requested by Patient
- Treatment
- Insurance
- Other

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cataract    Laser Vision Correction    Corneal Conditions    Corneal Surgery    Corneal Transplant    Uveitis  
 External Eye Conditions    Eye Inflammation    Eye Infections    Eye Injuries    Dry Eye    Adults & Children