RUTZEN
EYE SPECIALISTS
& LASER CENTER

ALLAN R. RUTZEN, M.D., F.A.C.S.

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: _____