UNIVERSITY EYE ASSOCIATES
Doctors of Optometry, P.A.
Excellence In EyeCare

University
8316-E Medical Plaza Drive
Charlotte, NC 28262
704-547-1551 Office
704-548-8017 Fax

Rocky River
9651-800 Brookdale Drive
Charlotte, NC 28215
704-536-6042 Office
704-563-5917 Fax

Davidson
455 S. Main Street, #100
Davidson, NC 28036
704-896-9090 Office
704-896-9680 Fax

Authorization to Release Health Information

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____

ADDRESS _____ DAY PHONE _____

CITY, STATE, ZIP _____ CELL PHONE _____

The above listed patient authorizes the following facility to release the information requested:

RELEASE TO: University Eye Associates

FROM

Physician: _____

Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____

Fax: _____

RELEASE FROM: University Eye Associates

TO

Physician: _____

Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____

Fax: _____

☐ All Medical Records ☐ Medical Records From ____/____/____ to ____/____/____

☐ Other _____

HEALTH INFORMATION PORTABILITY & ACCOUNTABILITY ACT (HIPAA) DISCLOSURES

The recipient of this Health Information may not use or disclose the Health Information unless another Authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. However, by signing this Authorization, I acknowledge that once the Health Information is released University Eye Associates has no control over the Health Information or its use thereof by any other party. This Authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this Authorization will expire thirty (30) days from the date signed below. This Authorization is fully understood and is made voluntarily on my part.

_____ _____

Signature: Patient/Parent/Guardian/Personal Representative **(circle one)** **Date**