

Columbia Eye Clinic, PA & Columbia Eye Surgery Center, Inc
Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Insurance Company _____
- Other _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____