SOUTHCENTER EYE CARE

DR. MAI X. NGUYEN & ASSOCIATES
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southcentereye@gmail.com

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

*MEDICAL RECORD RELEASE*

PATIENT NAME: DOB:
ADDRESS:
CITY/STATE/ZIP:
PHONE:

**SEND RECORD OUT**

I request and authorize Southcenter Eye Care to release information to:

Provider or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**RECEIVE RECORD**

I request and authorize the provider/clinic indicated below to release health information to Southcenter Eye Care:

Provider or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**** PLEASE EMAIL ALL RETINAL PHOTOS TO SOUTHCENTEREYE@GMAIL.COM ****

**Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition:**

**I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.**

Patient or Legal Guardian's Signature Date