CHRISTENBURY EYE CENTER

Jonathan D.
Christenbury, M.D.,

MEDICAL INFORMATION RELEASE

Authorization for Use and Disclosure of Information

Patient Name: _____

Address: _____

_____

Date of Birth: _____Social Security #: _____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the practice received the revocation.

I hereby authorize the use or disclosure of my individually identifiable health information as described below, I understand that this authorization is voluntary. I understand that when the information is used or disclosed, it may be subject to being re-disclosed and may no longer be protected by federal privacy regulations.

Description of Information:

_____

Purpose of Release: _____Patient Request _____Treatment by other Provider

I authorize that my clinic information be released **FROM**

Christenbury Eye Center
3621 Randolph Road # 100
Charlotte, N.C 28211
(704) 332-9365

TO (Please provide a fax number or an email address where a secure file can be sent)

_____

_____

_____

Patient or Patient's Representative Signature: _____

Printed Patient or Patients Representative: _____

Date: _____(Expires 180 days from date of signature)

To ensure completion in a timely manner, please submit ALL request no later than 01/31/2018.

3621 Randolph Road
Suite 100
Charlotte, NC 28211
704-332-9365
877-702-2020
Fax 704-364-7384

www.christenbury.com