



# CHRISTENBURY EYE CENTER

## MEDICAL INFORMATION RELEASE Authorization for Use and Disclosure of Information

Jonathan D.  
Christenbury, M.D.,

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 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