



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

\_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Social Security)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone Number)

**Authorizes:**

**Release of records to:**

**MICHAEL T. COURIS, MD**

\_\_\_\_\_  
(Name of Physician)

\_\_\_\_\_  
(Name of Physician)

**Vision Care and Correction San Diego**

\_\_\_\_\_  
(Name of Health Care Facility)

\_\_\_\_\_  
(Name of Health Care Facility)

**3969 4<sup>th</sup> Ave suite 301**

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

**San Diego, Ca 92103**

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(City, State, Zip Code)

**(619) 291-6191 / (619) 291-0049**

\_\_\_\_\_  
(Phone Number/ Fax Number)

\_\_\_\_\_  
(Phone Number/ Fax Number)

**Purpose or Need for Disclosure:**

The medical information/records will be used for the following purpose: on going treatment or \_\_\_\_\_

For The Following Dates: \_\_\_\_\_

**Information to be Released:**

- All Clinic Records
- Lab Reports
- Photographs
- Visual Fields/OCT's
- Office Notes
- Other

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to: (check all that apply)

- Mental Health
- AIDS Test Results
- Drug/ Alcohol/ Substance Abuse
- Developmental Disabilities
- AIDS-released disease
- Other

This Authorization Shall be effective immediately and remain in effect until: \_\_\_\_\_

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed. This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request. A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization. Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

\_\_\_\_\_  
Signature of Patient or Legal rep

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

- Parent or guardian of minor patient who could not have consented to health care.
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of deceased patient

**PLEASE SEND RECORDS BY FAX**