3969 4th Avenue,
Suite 301,
San Diego, CA 92103

Vision Care
and Correction of San Diego
Medical, Surgical & Laser Eye Care

Michael T. Couris, MD Inc.
Kelly Keefe MD INC.
Phone (619) 291-6191 Fax (619)291-0049

Suzanne P. handler MD Inc.
Phone (619) 336-2843 Fax (619) 291-0049

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:

KELLY KEEFE, MD
(Name of Physician)
Vision Care and Correction San Diego
(Name of Health Care Facility)
3969 4th Ave suite 301
(Street Address)
San Diego, Ca 92103
(City, State, Zip Code)
(619) 291-6191/ (619) 291-0049
(Phone Number/ Fax Number)

Release of records to:

_____
(Name of Physician)
_____
(Name of Health Care Facility)
_____
(Street Address)
_____
(City, State, Zip Code)
_____
(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
- ❑ Visual Fields/OCT's
- ❑ Lab Reports
- ❑ Office Notes
- ❑ Photographs
- ❑ 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
- ❑ Developmental Disabilities
- ❑ AIDS Test Results
- ❑ AIDS-released disease
- ❑ Drug/ Alcohol/ Substance Abuse
- ❑ 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