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

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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:**
	KELLY KEEFE, MD
(Name of Physician)	*(Name of Physician)*
	Vision Care and Correction San Diego
(Name of Health Care Facility)	*(Name of Health Care Facility)*
	3969 4th 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
- ❑ 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