Fuquay Ophthalmology & Glaucoma, PC

Dr. Kenneth Roach
605 Attain St, Suite 101
Fuquay Varina, NC 27526
Tele: 919-567-3709
Fax: 919-567-3710

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form permits _____ to release the patient's health information for the purpose(s) described below. Tele Number: _____ Fax Number: _____

Patient Name:_____

Date of Birth: _____**Social Security #:**_____

Mailing Address: _____

_____

RECIPIENT(S): This practice may use and/or release the information checked below to the following person or entity for the purpose(s) listed on this form.

Name: Fuquay Ophthomalogy & Glaucoma, PC Dr. Kenneth Roach

Fax (919) 567 - 3710 **Phone: (919) 567-309**

Mailing Address: 605 Attain St, Suite 101 Fuquay Varina, NC 27526

CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR RELEASED:

□ Entire record □ Billing/insurance records □ Office visit notes

□ Lab/diagnostic results related to: _____ □ Records from: _____ to _____
(Street)

□ Records specific to a certain condition/treatment: _____

□ Clinical images (e.g., X-ray) □ Other (describe): _____

PURPOSE FOR THE USE OR RELEASE:

□ Patient Request □ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any release of information that happened before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after being sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ _____

Signature Date

_____

Printed Patient Name