General Ophthalmology

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RECORDS TRANSFER AUTHORIZATION

I hereby authorize the use or disclosure of the defined information *from:*

_____

_____

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_____

Description of the specific information to be used or disclosed: *any/all medical records, labs, radiology, and photographs for the purpose of continuation of care ;* _____

_____

Person authorizing and requesting the information to be used or disclosed:

Name_____ DOB:_____

Address_____

_____

Recipient of the information:

NORTHERN WATERS OPHTHALMOLOGY SC
2111 BEASER AVENUE
ASHLAND WI 54806
(715) 682-0363

I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed;
- I may revoke this authorization in writing by contacting the office at the above address, attention to Privacy Officer;
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA;
- I may refuse to sign this authorization and that you will not condition treatment or payment to me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient signature: _____ Date:*_____

Relationship to patient if signed by representative:_____

*This authorization will expire in one year from the date signed unless notified by written request to expire prior to this date.