Ophthalmic Plastic and Reconstructive Surgery

John A. Long
MD, FACS

Matthew G. Vicinanzo
MD, FACS

Katherine A. Orman
MD (Fellow)

Cornea, External Disease and Anterior Segment

Kristin C. Bains
MD

Walter T. Parker
MD

Pediatric Ophthalmology and Strabismus

Jennifer D. Davidson
MD

Colette M. Jackson
MD

Allison C. McKelvey
OD

Administrator
Brooke E. Dover
CPA

Authorization for Release of Information from Alabama Ophthalmology Associates, P.C.

Patient's Name: ____

Date of Birth: ____

I authorize **Alabama Ophthalmology Associates, P.C.** to disclose the following protected health information (please describe what information you would like to be released; i.e. last chart note or all health information):

____

____

Please send the above information to (please include complete address):

____

____

This authorization shall be in effect until ______________________ (please specify date or event) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____
Signature of Patient or Personal Representative (Parent or Guardian)

____
Date

____
Name of Patient or Personal Representative **and** Relationship to Patient

1000 19TH STREET SOUTH • BIRMINGHAM, ALABAMA 35205 • P (205) 930-0700 F (205) 930-9127 • AOAPC.COM

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Authorization for Release of Information to Alabama Ophthalmology Associates, P.C.

Patient's Name: ______________________________

Date of Birth: ______________________________

I authorize ______________________________

Address: ______________________________

Phone: ______________________________

to disclose the following protected health information (please describe what information you would like to be released; i.e. last chart note or all health information) to **Alabama Ophthalmology Associates, PC** (the Company), 1000 19th Street South, Birmingham, AL 35205:

____

____

____

This authorization shall be in effect until ______________ (please specify date or event) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Company. I understand that that a revocation is not effective to the extent that the Company has relied on the use or disclosure of the protected health information.

____
Signature of Patient or Personal Representative (Parent or Guardian)

____
Date

____
Name of Patient or Personal Representative **and** Relationship to Patient