



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

**Ophthalmic Plastic and  
Reconstructive Surgery**

John A. Long  
MD, FACS

Matthew G. Vicinanza  
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

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