Leonard M. Parver, M.D.
Robert F. Stephens, M.D.
David L. Parver, M.D.
Fadi P. Nasrallah, M.D.
Jordan L. Heffez, M.D.
Nishi Gulati, M.D.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

______________________________ Patient Name (Please Print)

______________________________ Guardian or Authorized Party Name

______________________________ Social Security Number

______________________________ Date of Birth

I authorize the use and disclosure of my health information as described below:

Information requested:

___ Records relating to treatment dates from: ___________ to: __________

___ Records for all care at this facility or by Doctor____________________

___ I give my healthcare provider permission to discuss/disclose protected health information with/to______________________(Name of Individual)

Information to be released:

( ) from ( ) to

______________________________ Name

______________________________ Address

____

______________________________ Phone

______________________________ Fax

( ) from ( ) to

Retina Consultants, P.C.

☐ 6410 Rockledge Drive Suite 400
Bethesda, MD 20817
T: 301-530-5200 F: 301-493-6577

☐ 1145 Nineteenth St., NW Suite 500
Washington, D.C. 20036
T: 202-833-1668 F: 202-833-4698

☐ 3289 Woodburn Rd Suite 270
Annandale, VA 22003
T: 703-849-8601 F: 703-849-8605

Form in which records are to be released:

☐ Paper Copies
☐ Flash Drive ($25 upfront charge)

☐ Mail
☐ Fax
☐ Pick up

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage. I understand that uses and disclosures already made based upon my original permission cannot be taken back. **I understand that the medical records to be released may contain information related to HIV status, AIDS, Sexually Transmitted Diseases, alcohol, or mental health services, and I hereby authorize the release of the information.** To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in a year from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

I understand that Retina Consultants, P.C. may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

______________________________ **Signature of Patient or Guardian**

______________________________ **Date**

A fax copy or photocopy of this consent shall be as valid as original. If this authorization is signed by a patient's personal representative, the representative authority is based on ________________________.
(Law, Court order, POA, Parent, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproducing and forwarding records directly to other physicians.

For office use only:

Physician Authorization: ______________________ Date Sent: _____________ By: _________