Leonard M. Parver, M.D.
Robert F. Stephens, M.D.
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Jordan L. Heffez, M.D.
Erwin C. Puente, M.D., Ph.D.

CAPITAL EYE CARE, LLC

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

_____ _____
Patient Name (Please Print) Guardian or Authorized Party Name

_____
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 ( ) from ( ) to

_____
Name
_____
Address
_____
_____
Phone
_____
Fax

Capital Eye Care, LLC.- Retina Consultants

☐ 6720A Rockledge Drive Suite 200
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

☐ 431 Park Ave Suite 103
Falls Church, VA 22046
T: 703-534-3331 F: 703-534-0704

Form in which records are to be released:

☐ Paper Copies
☐ Flash Drive ($35 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.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproducing and forwarding of medical records. Black and White copies of last 4 visits free, if more is necessary, a Preparation fee of $22.88, plus $0.76 per page, plus postage will be charged.

I understand that Capital Eye Care, LLC - Retina Consultants 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.)

.***For office use only:***
Physician Authorization: _____ Date Sent: _____ By: _____