Rock Hill Eye Center
1565 Ebenezer Rd, Rock Hill, SC 29732

AUTHORIZATION TO RELEASE HEALTH/FINANCIAL INFORMATION

Chart #: _____

Patient Name: _____ DOB: _____
Address: _____

The Rock Hill Eye Center is authorized to release health information about the above named patient to the person(s) and/or doctor's office(s) listed below. If you do not wish for your information to be released to anyone, please mark through this section and sign.

Name : _____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you prefer only certain information be given out to the above listed, please explain any limitations:

_____
_____
_____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the information to be disclosed . I understand that revocation is not effective in cases where the information has already been disclosed but will be effective from the time we are notified of the revocation and anytime AFTER that.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF ROCK HILL EYE CENTER PRIVACY PRACTICE NOTICE

I have received a copy of the Notice of Privacy Practices for the ROCK HILL EYE CENTER.

SIGNATURE: _____ DATE: _____