ASCEND EYE CENTER
ADVANCED EYE CARE & SURGERY

755 Highland Oaks Drive, Ste 202
Winston Salem, NC 27103

Phone (336) 997-4599
www.ascendeye.com

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name_____ Date of Birth _____

Address_____ City/State/Zip_____

I Hereby Authorize the Disclosure of my Health Information From: *(SEND COMPLETED FORM TO THIS OFFICE)*

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

Ascend Eye Center
Name of Person/Organization Receiving Information

755 Highland Oaks Drive, Ste 202 Winston Salem, NC 27103
Address City / State / Zip

(P) 336-997-4599 (Secure Electronic Portal) Scheduling@ascendeye.com
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____ Complete Medical Record

_____ Medical Records for Specific Dates of Service from _____ to _____

X Other Dr. Ding's most recent chart note, any past testing (visual fields, all OCT's, IOL calculations), and imaging reports

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____
Description of Personal Representative's Authority (attach necessary documentation) Date

Date Sent_____ By_____ Via_____