ANDERSON & CHHABRA EYECARE CENTER
719 W. Fletcher Avenue
Tampa, FL 33612
Phone (813) 961-2020
Fax (813) 961-4105

PATIENT DISCLOSURE AUTHORIZATION

Patient Name: ______________________________ Date of Birth: ____________________

I authorize disclosure of my vision records from (date) ______________ to ______________
(If no date specified, entire records will be disclosed).

Name of Doctor/Facility authorized to release my records:

____

Address:____ Phone:_______________

Name of Doctor/Facility authorized to receive my records:

____

Address: ____ Phone: _______________

This Authorization will expire on the following date _________________(if no date specified, Authorization expires in sixty (60) days.

- I understand that I may revoke this Authorization at any time by submitting a written notice to the Custodian of Records at the location where records are located.
- I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Anderson Eyecare Center, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information.

Signature: ____ Date: _________________

Relationship to Patient (if signed by a personal representative of Patient): ______________________