CHRISS & ASSOCIATES, M.D., P.A.
OPHTHALMOLOGY
DISEASES AND SURGERY OF THE EYE

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name: ____ Date of Birth: ____________________

Address: ____City / State / Zip: ____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION: TO / FROM

Chriss & Associates, M.D., P.A.

1925 Mizell Avenue, Suite 302, Winter Park, FL 32792

Phone: 407.629.6646 Fax: 407.740.5089

TO RELEASE MY INFORMATION: TO / FROM

____
Name of Person / Organization Receiving Information

____
Address *City / State / Zip*

____
Phone Number // Fax Number

THIS AUTHORIZATION REMAINS IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.
THIS MEDICAL RECORDS RELEASE IS VALID FOR 90 DAYS FROM DATE OF THE REQUEST.

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 above. 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. Chriss & Associates, M.D, P.A. recognizes the patient's right to access and obtain copies of their protected health information (PHI) in accordance with all federal and state laws. Should you require any behavioral health records, state law requires physician approval prior to our releasing any medical records to you. Please allow an additional 3-4 business days for these requests to be processed.

X ____
Printed Name of Patient OR Personal Representative

X ____
Signature of Patient OR Personal Representative *DATE*

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

X ____
Witness

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INFORMATION TO BE RELEASED:
______ Last three (3) Office Visits
______ Medical Records for Specific Dates of Service (please list) from _____________ to _____________
______ Other (please list) ____

Date sent: _______________ ***by:*** _______________ ***via:*** _______________