Advanced Eyecare of Orange County/ Kim T. Doan, M.D.

355 Placentia Ave #305 Newport Beach, CA 92663 Phone: 949.645.6300
19582 Beach Blvd #310, Huntington Beach, CA 92648 Phone: 714.965.0300

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax and other electronic methods.

To: **Advanced Eyecare OC/Kim Doan, M.D.**
355 Placentia Avenue, #305
Newport Beach, CA 92663

The medical information/records will be used for the following purpose:________________________________

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

Please release the following information:

______ Pachymetry ______History&Physicial Exam ______Surgical Reports
______Treatment Plans ______Consultation Reports ______Progress Notes
______ Visual Fields ______Refraction/IOL ______Pre/Post LASIK records

[ ] Limited to the following medical information:____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial) Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial) HIV Diagnosis/Treatment _________(initial)
Genetic information ________(initial)

DURATION This authorization shall be effectively immediately and remain in effect until _________________.
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

______________________________ ______________________________
Signature of patient or *legal/personal representative* Relationship *if other than patient*

______________________________ ______________________________
Patient's Name (PRINT) Date

______________________________ ______________________________
Patient's Social Security Number Patient's Date of Birth