

Kutryb Eye Institute
407 S. Washington Ave
Titusville, FL 32796
Tel 321-267-2020
Fax 321-267-4165

Kutryb Eye Institute
2568 S. Ridgewood Ave Ste 4
Edgewater, FL 32141
Tel 386-424-1422
Fax 386-424-1401

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ DOB _____ Home Phone _____

Address _____

City _____ State _____ Zip Code _____

Hereby authorize Kutryb Eye Institute to release and/or request medical, psychiatric, drug abuse, alcohol, and or HIV testing/aids information contained in my medical records. Check One: Release To _____ Obtain from: _____

Healthcare Provider _____

Address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

I would like my records to be: Mailed _____ Faxed _____ Pick-up _____

The protected health information is being used or disclosed for the following purpose(s):

Healthcare _____ Legal _____ Personal _____ Other _____

I understand that this consent is revocable upon written notice to Kutryb Eye Institute, except to the extent that action taken by Kutryb Eye Institute has been taken in reliance on the authorization, and that this authorization shall remain in force until _____. (Or 180 days) in order to affect the purpose for which it is given. Protected health information, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

I release Kutryb Eye Institute and its employees from any and all liability from release of said information at my direction.

Signature of Patient, Parent, Legal Guardian.

If not patient, state relationship

Date