Kutryb Eye Institute

730 South Washington Ave

Titusville, FL 32780

Phone: 321-267-2020

Fax: 321-267-4165

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 form 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. I f not patient, state relationship

_____

Date