GERSTEIN EYE INSTITUTE

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Authorization To Use or Disclose Health information

Patient Name:_____ Date of Birth:_____

I authorize the use or disclosure of the above named individual's Health Information as described below.

The following individual(s) or organization(s) are authorized to make the disclosure:

GERSTEIN EYE INSTITUTE- DR. MELVYN GERSTEIN, DR. CRAIG GERSTEIN
3042 W PETERSON AVE. CHICAGO, IL 60659

The type of information to be used or disclosed is as follows
(Check the appropriate lines and include other information when indicated.)

O All my health information including but not limited to AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/ Psychiatric Care Alcohol and/or Drug Abuse Treatment, If any, unless specifically excepted._____

O My Health Information relating to the following treatment or condition:_____

O My Health Information for the date(s):_____

O Consultation Reports from: (Please provide doctor's name.)_____

O Other: (Please describe) _____

The information identified above may be used by or disclosed to the following individual or organization(s):

Name: _____

Address: _____

Phone/Fax number: _____

This information for which I'm authorizing disclosure will be used for the following:
O My Personal Records O Sharing with other Health Providers as needed O Other (please describe)_____

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present my written revocation to the appropriate medical office. I understand that it will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, the recipient may be redisclosed. Federal privacy laws or regulations may not protect the information. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. Also, a fee may apply to release any medical records for personal use. If sent to another doctor our office will forward records at no cost.

This authorization will expire _____. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient

_____ _____
Signature of Witness Date