

**ROCK HILL EYE CLINIC, PA
OPHTHALMOLOGY
Rock Hill, South Carolina 29732-1806**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

With your permission, we may disclose your Protected Health information to a family member, relative, close friend or any other person you identify that is directly involved in your health care.

I, _____, authorize Rock Hill Eye Clinic, PA to release any personal information relating to my health care

To _____ RELATIONSHIP TO PATIENT: _____

To _____ RELATIONSHIP TO PATIENT: _____

To: _____ RELATIONSHIP TO PATIENT: _____

To: _____ RELATIONSHIP TO PATIENT: _____

I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

_____ No Restrictions

_____ With Restrictions (please list): _____

I have received a copy of the Notice of Privacy Practices for the Rock Hill Eye Clinic. I hereby acknowledge that I am familiar with and understand the terms and conditions.

Signature

Chart # _____

Date

Date
