The Abel Center for Oculofacial Plastic Surgery

Authorization to Release Information

I, _____, give permission to The Abel Center to disclose the following information from my health records. Any information listed below that I have **crossed out** may **not** be released. I give consent for the following information to be released:

1. Complete Health History
2. History and Physical Examinations
3. Consultation Reports
4. X-Ray Reports
5. Discharge Summary
6. Progress Notes
7. Laboratory Results
8. Photos or Other Images

I understand this may include personal information relating to AIDS, HIV INFECTION or HEPATITIS INFECTION.

The above information **may** be disclosed to or received by:

- ATTORNEY
- HOSPITAL (ADMISSION)
- INSURANCE COMPANY
- MEDICARE (CLAIMS ISSUES)
- OTHER CARE GIVERS (REFERRALS FOR ADDED CARE)

I also give consent for messages from The Abel Center to be released to:

___ Home Voicemail Phone Number: (_____) _____ - _____

___ Work Voicemail Phone Number: (_____) _____ - _____

___ Spouse Name of Spouse: _____ Phone Number: (_____) _____ - _____

___ Child Name of Child: _____ Phone Number: (_____) _____ - _____

___Other Name and relationship: _____ Phone Number: (_____) _____ - _____

I prefer to be contacted at: ____ Work Phone Number: (_____) _____ - _____

____ Home Phone Number: (_____) _____ - _____

____ Cell Phone Number: (_____) _____ - _____

I understand that this consent will remain a permanent part of my medical record and that it does not expire. I also understand that I may, at any time, revoke this consent, or any part thereof, in writing. I understand that The Abel Center will do all in their power to see that any personal information is maintained in a professional manner and only released to those that it deems appropriate to receive said information. I also understand that The Abel Center is required by Law to maintain the privacy of, and provide individuals with, this notice of their legal duties and privacy practices with respect PHI. If you have any objections to this form, please ask to speak out to HIPPA Compliance Officer in person or by phone at (302) 998-3220. My signature on this form acknowledges my completion of the above information and that I received a copy of The Abel center's Notice of Privacy Practices.

Patient Name: _____ DOB: _____/_____/_____

Print Name:_____

Signature:_____ Date: _____/_____/_____

Signature of Staff Member: _____ Date:_____/_____/_____