DOTHAN OPHTHALMOLOGY, P.C.
Dothan Ophthalmology
1750 West Main Street
Dothan, AL 36301

PROTECTED HEALTH INFORMATION RELEASE FORM

I give permission for Dothan Ophthalmology to release my protected health information to the following individuals or facilities:

NAME	RELATIONSHIP	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand I have the right to revoke this authorization in writing, at any times, except (1) where uses or disclosures have already been made upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to:

Dothan Ophthalmology 1750 West Main Street, Dothan, AL 36301

I understand it is possible that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the federal Privacy Standards.

I have received a copy of Dothan Ophthalmology's privacy Policy and Privacy Practices

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Print Name of Patient **Chart#**

_____

Print Name of Guardian

If an authorization is signed by an individual's personal representative, the representative's authority is based on:_____ (state law, court order, etc.)