GLAUCOMA CENTER OF SAN FRANCISCO

55 Stevenson Street
San Francisco, CA 94105
Tel: (415) 981-2020
Fax: (415) 981-2019
frontdesk@glaucomasf.com
www.glaucomasf.com

Andrew G. Iwach, M.D.
Shan C. Lin, M.D.
Terri Pickering, M.D.
Sunita Radhakrishnan, M.D.
Sophia Hsiao, O.D.

Emeritus
H. Dunbar Hoskins, Jr., M.D.
Robert N. Shaffer, M.D., *1912-2007*
John Hetherington, Jr., M.D., *1930-2020*

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

I Hereby Authorize the Disclosure of My Health Information From:

_____
Name of Person / Organization Releasing Information

_____ _____
Address City / State / Zip Code

_____ _____
Phone Number Fax Number

To Release My Information To:

Glaucoma Center of San Francisco
Name of Person / Organization Receiving Information

55 Stevenson Street San Francisco, CA 94105
Address City / State / Zip Code

(415) 981-2020 (415) 981-2019
Phone Number Fax Number

Information to be Released:

□ Complete Medical Records □ Eye Records
□ Visual Fields □ OCT Results □ Photos
□ Medical Records for Specific Dates of Service from _____ to _____
□ Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA)*. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
Printed Name of Patient or Personal Representative Date

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

****

Date Sent: _____ **By:** _____ **Via:** _____