



Dwayne B. Baharozian, MD
Eye Physician and Surgeon
Board Certified by American Board of Ophthalmology

*Glaucoma
Cataracts
Diabetic Eye Disease
Laser Surgery*

Authorization to Use and Disclose Health Information

Patient Name: _____ DOB: _____ Phone: _____

I hereby authorize the Family Eye Care Center & Optical Gallery, Inc. to release or obtain medical information to/from the individual/organization named below.

RECORDS RELEASED TO:	RECORDS OBTAINED FROM:
Name:	Name:
Street Address:	Street Address:
City/State/ZIP:	City/State/ZIP:

Treatment Dates: _____ Purpose of Request: _____

In compliance with Massachusetts Statutes which require specific authorization to release otherwise privileged information, please release records pertaining to: (Check all that apply)

<input type="checkbox"/> Substance Abuse (drug/alcohol) Treatment <input type="checkbox"/> Information related to sexually transmitted diseases <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Domestic Violence Victims Counseling <input type="checkbox"/> Sexual Assault Treatment <input type="checkbox"/> HIV, AIDS or ARC Information	<input type="checkbox"/> Communication between me, my psychiatrist, psychologist, or other behavioral health professional <input type="checkbox"/> Abortion consents/records or family planning services <input type="checkbox"/> Social Work Counseling/Therapy
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I understand that Federal Privacy Laws may no longer protect the information furnished once it has been released.

I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by the Family Eye Care Center & Optical Gallery, Inc. before the Family Eye Care Center & Optical Gallery, Inc. received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Family Eye Care Center & Optical Gallery, Inc.

This authorization is effect through **(check one)** ___ / ___ / ___ or NO Expiration unless revoked or terminated by the person or the patient’s personal representative.

The Family Eye Care Center & Optical Gallery, Inc. charges a fee of \$20.00 for the reproduction of medical records. Please allow approximately 14 business days for the records to be available.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name and Relationship if other than Patient: _____

Date Released: _____ Released By: _____