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)

☐ Substance Abuse (drug/alcohol) Treatment ☐ Information related to sexually transmitted diseases ☐ Genetic Testing ☐ Domestic Violence Victims Counseling ☐ Sexual Assault Treatment ☐ HIV, AIDS or ARC Information	☐ Communication between me, my psychiatrist, psychologist, or other behavioral health professional ☐ Abortion consents/records or family planning services ☐ Social Work Counseling/Therapy

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: _____

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