Family Eye Care Center & Optical Gallery

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

Glaucoma
Cataracts
Diabetis Eye Disease
Laser Surgery

Authorization to Use and Disclose Health Information

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 Counceling/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 or revocation in writing to the Family Eye Care Center & Optical Gallery, Inc.

This authorization is in effect through (check one) ☐ ____/____/____ or ☐ NO Expiration unless revoked or terminated by the person or the patient's personal representative.

All Medical Records are released on a CD. The Family Eye Care Center & Optical Gallery, Inc. charges a fee of $25 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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