Kaster Eye Clinic
Optical & Vision Care

1600 E Turkeyfoot Lake Rd., Suite A, Akron, OH 44312
Phone: 330.899.7161 • Fax: 330.899.7151

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name:** ________________________________________ **Date of Birth**: _________________________

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person/facility is authorized to disclose information about me:

______________________________________________________________________________

2. The following person may receive disclosure of protected health information about me:
*Dr. Brad P. Kaster, O.D., Kaster Eye Clinic, 1600 E. Turkeyfoot Lake Rd., Suite A, Akron, OH 44312*

3. Please specifiy the health information you authorize to be released:

☐ **Please fax Last Exam, including most recent tests to:** 330-899-7151

☐ **Please fax Complete Records to:** 330-899-7151

☐ **Please email Optomap retinal images to:** green@kastereyeclinic.com

4. What is the purpose of the use/disclosure:

☐ Changing providers; if yes, is this a permanent transfer of care? ☐ yes ☐ no

☐ Other __________________________________

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

6. I may revoke this authorization by notifying the disclosing person/facility in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

7. Unless otherwise revoked, this Authorization expires:______________________________(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. Please inquire if the disclosing person/facility requires payment.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Print Name | Date |
| ______________________________ | ______________________________ |
| Signature (Patient, Parent, Guardian) | Relationship to Patient (Parent, Guardian, or Patient Representative) |