BAILEY, WAKIL & AURINGER EYE PHYSICIANS & SURGEONS, PLLC

Thomas A. Bailey, M.D., F.A.C.S. Aida S. Wakil, M.D., F.A.C.S. David E. Auringer, MD

Authorization to Disclose Protected Health Information/Medical Records

PATIENT NAME _____ DATE OF BIRTH _____

I hereby authorize:

DOCTOR/PROVIDER NAME _____

ADDRESS _____

PHONE _____ FAX _____

To release copies of my entire medical file to:

Bailey, Wakil & Auringer Eye Physicians
222 Great Oaks Blvd.
Albany, NY 12203
518-452-6002 (ph) 518-452-6078 (fax)

1. This authorization will expire on _____, or one year from the date signed.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the provider(s) shown above. I understand that any revocation will not apply to records that have already been released in response to this authorization.
3. I understand that I have the right to refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form.
4. I have the right to receive a copy of this form after I sign it.

PATIENT SIGNATURE _____ DATE SIGNED _____