Kaster Eye Clinic
Optical & Vision Care

3705 Massillon Road, Uniontown, OH 44685
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, 3705 Massillon Road, Uniontown, OH 44685

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)