Horizon Eye Care

135 South Sharon Amity, Suite 100
Charlotte, NC 28211
704-405-4108
704-405-4093 (fax)

Patient Name: ____

Date of Birth: __________________ Phone: ______________________

Address: ____

City: __________________ State: __________ Zip: __________

The type and amount of information to be used or disclosed is as follows: (include dates)

Date of service: ______________

_____ Office notes _____ Special testing reports _____ Physician letters

_____ Operative notes _____ Lab/ X-ray reports _____ Other

I authorize the release of my health information from:

Name: ____

Address: ____

City: __________________ State: __________ Zip: __________

Phone: __________________ Fax: ______________________

Please forward/release my health information to:

Name: ____

Address: ____

City: __________________ State: __________ Zip: __________

Phone: __________________ Fax: ______________________

Patient Information: This authorization shall be in effect until the information has been forwarded as requested. I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed, but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to HIPAA Officer, Horizon Eye Care, 135 South Sharon Amity, Suite 100, Charlotte, NC 28211.

______________________________ ______________

Signature of patient or legal representative Date

Revised 09/2021