OPHTHALMOLOGY WEST, INC.
DIAGNOSIS AND TREATMENT OF THE EYE

Benjamin Milder, MD
(Retired)

Barry Milder, MD
Family Ophthalmology
Pediatric Ophthalmology
Strabismology
Lacrimal Disorders

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Family Ophthalmology
Cornea and External Disease
Laser Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____

Date of Birth: ______________________

Release Records To: ____

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Release Records From: ______________________________________

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I hereby authorize you to release (specific description of information)

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Rendered to me during the period from: ______________ to: ___________

The purpose of this release is: ___________________________________

Expiration date: ____

This authorization provides that:

- I have the right to revoke this authorization in writing to the Privacy Office at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information released can be redisclosed by recipient and is no longer protected by HIPAA.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

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Signature of Patient/Guardian

______________________ __________________________

Relationship to Patient (If signed by someone other than the patient)

______________ __________________________

Date of Release Witness

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