ALLAMAN EYE CARE & ASSOCIATES
CHRISTEN ALLAMAN, M.D.
1665 DOMINICAN WAY, SUITE 122, SANTA CRUZ, CA 95065
1667 DOMINICAN WAY, SUITE 130, SANTA CRUZ, CA 95065
PHONE: 831-476-1298; FAX: 831-476-9468
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RELEASE OF MEDICAL RECORDS AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I, _____ (DOB: _____/_____/____), hereby authorize the optometrist/ophthalmologist listed below to release my eye-related medical records:

From: Dr.'s Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

~~**To:**~~ **Allaman Eye Care**
Christen Allaman, MD
1665 Dominican Way, Suite 122
Santa Cruz, CA 95065
Phone: 831-476-1298
Fax: 831-476-9468

Please include the following information: Chart Notes, Surgical Information (including type of surgery, eye and dates), refractive information, pre-op biometry, refraction, keratometry, white to white, axial length (A-Scan & IOL Master), visual field testing, OCT's, HRT's, and Photos.

Other: _____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of healthcare information are prohibited from re-disclosing it except as specifically required or permitted by law.

Signature: _____ Date: _____

Relationship if other than patient: _____