VRA

Vitreo-Retinal Associates, P.C.

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Release of Health Information

Patient Name: _____ DOB: _____/_____/_____

I authorize _____
use or disclose my health information, as described below.

1. Description of health information that may be used and/or disclosed:
   _____
   _____

2. Name of organization who may receive and use the information:

   Vitreo-Retinal Associates, P.C.
   2505 East Paris Ave. SE Suite 100
   Grand Rapids, MI 49546

3. The purpose(s) for which the information will be used or disclosed:
   _____
   _____

4. I understand that I may revoke this authorization at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.

5. This authorization shall expire: _____

By signing below, I acknowledge that I have read and I understand this authorization form.

_____ _____/_____/_____
Signature of Patient or Patient's Authorized Representative ***Date***

If signed by Patient's Representative, please print name and describe the representative's authority to act for the patient:

Representative's Name: _____

Representative's Authority: _____