Reston Eye Associates, PLLC
1800 Town Center Drive, #316
Reston, VA 20190
Tel (703) 787-4700 Fax (703) 787-4707

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: ________________________________ Date of Birth: ____________________

By signing this form, I authorize the use and disclosure of my health information as described below:

1. Description of information:

___ All Clinical Medical Records

___ Other Records - Please List (e.g. billing, visual fields, nfla results):

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2. Name or identification of person(s) or class of persons authorized to make the disclosure:

___ Reston Eye Associates/Dr. Elle Milani

___ Other: ____

3. Name or identification of person(s) or class of persons authorized to receive the information (include address and phone number and/or fax number where health information should be sent):

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- I understand that I have the right to revoke this authorization, writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to Reston Eye Associates.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the federal Privacy Standards.
- I understand that I may inspect or copy any information used or disclosed under this authorization.

_____ [*Initials of patient or guardian*] I understand that Reston Eye Associates may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature: ________________________________ Date: ______________________________
Patient or Authorized Representative

________________________________ ________________________________
Print Name of Representative Relation to Patient (If Legal Guardian, So State)