

## Authorization For Release of Health Information

*I hereby authorize:* **Kim L. Cooper, MD** **Phone: (650) 259-0300**  
**1720 El Camino Real Suite 235** **Fax: (650) 259-0505**  
**Burlingame, CA 94010** **Email: frontdesk@mypedeyedr.com**

**To Disclose to:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Email to: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**RECORDS AND INFORMATION PERTAINING TO:**

Name of patient:	Date of Birth:	Date last seen:
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Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Fees/Delivery** **There is a \$40.00 Prepayment Fee for medical records. Please allow 30 business days for processing. Delivery by secure email.**

**Revocation:** This authorization is also subject to written revocation by the patient/parent at any time. The written revocation will be effective upon receipt.

**Re-disclosure:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**Duration:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here:

**Records to be released:**  All eye examinations, contact lens exams, consult letters, visual field reports, photography, other ophthalmologic reports or tests.

Authorization to release health information is voluntary. Physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized disclosure to someone not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except as follows: 1) to obtain information in connection with eligibility or enrollment in a health plan, 2) to determine an entity's obligation to pay a claim, or 3) to create health information to provide to a third party.

**Date:** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Please indicate your relationship to the patient:**  
 Self  Spouse  Parent  Guardian  Conservator  Other

This message and its' contents are legally privileged and confidential information intended solely for the use of the addressee. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, copying or other uses of this message and its' contents is strictly prohibited. If you have received this message in error, please notify Kim Cooper, MD immediately at front desk @mypedeyedr.com or call 650-259-0300 and return the original message to us.