

**WAKE OPHTHALMOLOGY ASSOCIATES, P.A.**

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**Authorization to Release Information to a Health Care Provider**

\_\_\_\_\_  
Patient's name (print) Date of Birth

\_\_\_\_\_  
Street Address City, State, Zip

I authorize the use and disclosure of the Protected Health Information for the above named patient as described:

Information Requested:

\_\_\_\_\_ Records relating to treatment dates from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Records for all care at the facility or by this doctor

\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as described in this document. I can do this by written notification. I understand that my treatment will not be conditioned on signing this document. I understand that I have the right to refuse to sign this authorization.

Information to be released ( ) from ( ) to Wake Ophthalmology  
105 S.W. Cary Parkway, Suite 200  
Cary, NC 27511  
Phone 919-467-4500  
Fax 919-460-9339

( ) from ( ) to \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative Date

\_\_\_\_\_  
Personal Representative's name printed (if applicable)

\_\_\_\_\_  
Description of Personal Representative's Authority (attaché necessary documentation)