Waterford Lakes Eye Care
Dr. Vijay Nair

448 S Alafaya Trail, Suite 7 ▪ Orlando, FL 32828 ▪ (O) 407-382-6011 (F) 407-382-6234

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____ (Dr/Facility/Agency)
to disclose the following information from health records of: (FS 395.3025)

Patient's Name: Last_____First_____Middle_____

Soc Sec#: _____ Date of Birth: _____

Information to be disclosed (Please check):
_____Complete Records _____Glasses Prescription _____Contact Lens Prescription
_____Last Exam Notes _____Retinal Imaging/OCT
_____Other _____

Release To:

□ Dr. Vijay Nair, O.D., P.A
448 S. Alafaya Trail Suite 7
Orlando, Florida 32828
Tel: (407) 382-6011
Fax: (407) 382-6234

□ Myself

□ Other _____

As required by state and federal law, Vijay Nair, O.D., P.A. may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the person/entities listed above without my further authorization, but that Vijay Nair, O.D., P.A., cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Vijay Nair, O.D., P.A., 448 S. Alafaya Trail Suite 7, Orlando, and Fl 32828. I further understand that any such revocation does not apply to information released in response to this authorization.

I hereby release Vijay Nair, O.D., P.A., and its employees from any and all liability that may arise from the release of information as I have directed.

Patient's Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Relationship to Patient (If other than Patient): _____