LAKESIDE EYE
ASSOCIATES
16525 Birkdale Commons Parkway
Huntersville, NC 28078
Phone: 704-896-3311
Fax: 704-896-5514

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO LAKESIDE EYE ASSOCIATES

I hereby authorize (name of provider)_____, (phone #) _____, (address) _____ to disclose the following information from the health records of:

_____ (Print Full Legal Name)

_____ (Date of Birth)

_____ (Street Address)

_____ (Home Phone Number)

_____ (City, State, Zip Code)

_____ (Work Phone Number)

- o Complete Health Record
- o Spectacle Prescription
- o Contact Lens Prescription
- o Other: _____

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, or both your HIV-related and medical information. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

____ I do _____I do not authorize the release of information related to HIV / AIDS.

I certify that this request has been made voluntarily, and this authorization will expire one year from the signed date:

_____ (Patient Signature)

_____ (Date signed)