Retina Associates of Missouri, P.C.

Jerry R. Blair, M.D., Ph.D.
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Wayne E. Davis, D.O.
Vitreoretinal Diseases and Surgery

Date: _____

Patient Name: _____
Address: _____
_____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form I authorize my physician to use and disclose my health information including the diagnosis and records of any treatment or examination rendered to me to:

Please list name or identification of person(s) authorized to receive the information:

- _____
- _____
- _____
- _____
- _____
- _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand the uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Retina Associates of Missouri, P.C., 3600 Amron Court, Columbia, MO 65202.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the Federal Privacy Standards.

Signature: _____

Print Name: _____
Date of Birth: _____
Social Security Number: _____

Witness Signature: _____