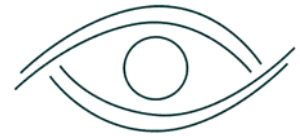


Eye Surgery Associates



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

_____	_____
Patient Name	Guardian or Authorized Party Name (if applicable)
_____	_____
Social Security Number	Date of Birth

I authorize the use and disclosure of my health information as described below.

Information Requested: _____ Records relating to treatment dates from: _____ to _____

_____ Records for all care at this facility

_____ Other (Please Specify) _____

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 that the uses and disclosures already made based upon my original permission cannot be taken automatically expire in 90 days from today's date.

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

Information to be released from to _____

from to **Eye Surgery Associates**

_____ Lee R. Duffner, M.D., F.A.C.S.
 _____ Joel Sandberg, M.D., F.A.C.S.
 _____ Arthur Fishman, M.D., F.A.C.S.
 _____ Mark Dorfman, M.D., F.A.C.S., F.A.A.P.

_____ Patrick Rubsamen, M.D.
 _____ Guy Angella, M.D., F.A.C.S.
 _____ Scott Cardone, M.D.
 _____ David T. Jones, M.D., Ph.D.

_____ 2740 Hollywood Blvd., Hollywood, FL 33020 • 954-925-2740 • Fax: 954-342-0028
 _____ 603 N. Flamingo Rd., Suite 250, Pembroke Pines, FL 33028 • 954-431-2777 • Fax: 954-431-1856
 _____ 2300 N. Commerce Pkwy, Suite 307, Weston, FL 33326 • 954-217-3155 • Fax: 954-217-3156

_____ Signature of Patient (or Guardian) _____ Date

A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/ psychiatric conditions, I DO

_____ DO NOT _____ authorize the release of this information.

** If this authorization is signed by an individual's personal representative, the representative's authority is based on:

_____ (e.g., state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The most recent three visits are at no charge, and a \$.50 for each remaining page.***Please allow a minimum of 7-10 business days to process your request.***

For office use only:

Physician Authorization _____ Date Sent: _____ By: _____