



BARRY J. WOLSTAN, MD | DAMIEN F. GOLDBERG, MD | DAVID A. MARKMAN, MD | T. MAI PHAN, MD

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

In compliance with the HIPAA Patient Privacy Policy, this authorization allows Wolstan & Goldberg Eye Associates to release any of your protected medical information to individuals that you wish to specify.

I hereby authorize Wolstan & Goldberg Eye Associates to release information regarding my medical history and treatment by means of verbal communication via phone or in person, by mail or fax, to the person(s) listed below:

Name and Relationship to Patient

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If it becomes necessary to contact you by phone, please list the number(s) where you wish us to call.

Phone number and type of phone line (home, cellular, business, etc.)

May we leave messages, such as lab results, appointment reminders, or other medical information on an answering device, or with another person who answers the phone at that location?

Yes

No

RESTRICTIONS:

Permission for further use or disclosure of this medical information is NOT granted unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient or legal representative

Relationship

Patient's Name and Date of Birth (PRINT)

Date