



**PROVIDENCE**  
EYE & LASER SPECIALISTS

**AUTHORIZATION FOR RELEASE AND/OR  
DISCLOSURE OF MEDICAL INFORMATION**

Treatment, payment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM:**

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Name of Medical Office/Hospital

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

Please **SEND** Medical Information **TO:**

**Reza Michael Mozayeni, M.D.**  
\_\_\_\_\_  
Name of Health Care Provider

**Providence Eye & Laser Specialists**  
\_\_\_\_\_  
Name of Medical Office/Hospital

**3025 Springbank Lane, Suite 200**  
\_\_\_\_\_  
Street Address

**Charlotte, North Carolina 28226**  
\_\_\_\_\_  
City, State and Zip Code

Phone: (704) 540-9595 Fax (704) 540-9616

**I hereby authorize \_\_\_\_\_ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. Release and / or disclose records and information regarding:**

<b>Name of Patient</b> (List Other Names Used)		Medical Record Number	Date of Birth
_____		_____	( )
Address	City	State Zip Code	Telephone Number
_____	_____	_____	_____

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature if no date entered.

**REVOCAION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**REDISCLASURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:** Check the box and initial which type of information is to be released and / or disclosed:

- Eye Records** (from initial visit to \_\_\_\_\_)
- Information Regarding Specific Injury or Treatment** (from \_\_\_\_\_ to \_\_\_\_\_)
- X-Ray (check one or both):**     **Films**     **Reports**
- Laboratory Results**
- Other (specify):**

**I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only:**

\_\_\_\_\_  
A copy of this authorization is valid as an original.  
I have the right to receive a copy of this authorization. The copy is for me to keep.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
Indicate Relationship (If signed by Other than Patient)