Christopher Spellman, M.D.
Ophthalmology

Patient Representative Release Authorization

By completing this form I authorize Christopher Spellman, M.D. Inc. to discuss/release my protected health information to one or more representative I identify on this form. I may add or delete individuals at any time by completing this authorization. I give permission to Christopher Spellman, M.D. Inc. to discuss/release protected health information with the below named party (s).

Patient Information

Name: _____ Date of Birth: _____

Home Phone #: _____ Mobile Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Representative (s):

Please identify your Patient Representative. Please ensure that the designated individual(s) below will need to provide the following information on you prior to Christopher Spellman, M.D. Inc. discussing/releasing personal health information on your behalf:

● Patient Name ● Patient Date of Birth ● Patient Address

In addition they will also be asked to provide their name and date of birth for identification purposes only.

Please circle one of the following: *Add* *Delete*

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: *Please check one*

☐ All medical information ☐ Other: _____

I authorize *Christopher Spellman M.D., Inc* to discuss my medical care with the individual(s) identified above. I understand there is no expiration date, and I may add or delete individuals at any time by completing a new authorization. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to *Christopher Spellman, M.D. Inc*. I understand the revocation will not apply to information that has already been provided in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Christopher Spellman, M.D. Inc. at 760-633-3377.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____