Advanced Eyecare of Orange County/ Kim T. Doan, M.D.

3333 W. Coast Hwy #201 Newport Beach, CA 92663 Phone: 949.645.6300
19582 Beach Blvd #310 Huntington Beach, CA 92648 Phone: 714.965.0300

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax and other electronic methods.

To: **Advanced Eyecare OC/Kim Doan, M.D.** **Fax: 949.645.6020**
351 Hospital Rd #100
Newport Beach, CA 92663

The medical information/records will be used for the following purpose:_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
Please release the following information:

_____ Pachymetry	_____History&Physicial Exam	_____Surgical Reports
_____Treatment Plans	_____Consultation Reports	_____Progress Notes
_____ Visual Fields	_____Refraction/IOL	_____Pre/Post LASIK records

[ ] Limited to the following medical information:_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial) Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial) HIV Diagnosis/Treatment _____(initial)
Genetic information _____(initial)

DURATION This authorization shall be effectively immediately and remain in effect until _____.
Date

RESTRICTIONS

Permissions 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 of 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/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth