



**Patricia W. Smith, M.D.**  
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**Authorization for Release of Information**

**Patient Information**

Name of Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_

Triangle Eye Physicians, P.A., is authorized to release protected health information about the above named patient to the entities named below.

**Entity to Receive Information (Initial each that is subject to this authorization):**

\_\_\_\_\_ Leave information in my person voice mail/answering machine.

\_\_\_\_\_ Give information to the following person(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

**Description of Information to be released (Initial each that is subject to this authorization):**

\_\_\_\_\_ Financial Information  
\_\_\_\_\_ Medical Information  
\_\_\_\_\_ Other Information as Described:  
\_\_\_\_\_

**Rights of the Patient:**

I understand that I have the right to revoke this authorization at anytime in writing, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to:

Triangle Eye Physicians, P.A.  
Attn: Privacy Officer  
2406 Blue Ridge Road, Suite 280  
Raleigh, NC 27607

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority (attach Necessary Documentation)