AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

THE VITREORETINAL EYE CENTER, PC
Avit "Frere" Gremillion, M.D.

I authorize my physician, administrative, and/or clinical staff to disclose my Protected Health Information as detailed below:

- ☐ Full medical record held by this office from first date of service to present.
- ☐ Medical record for the period _____through_____only.
- ☐ A specific portion/section of the record as follows:

  _____
  _____
  _____

to the following people. (Examples: spouse, relatives, children, and/or anyone involved in your medical care.)

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

_____ initials I acknowledge and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization shall be in force and effect until_____(one year from today's date) at which time this authorization to use or disclose your protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to ATTN: Natalie Loyacano at 962 Tommy Munro Dr., Suite B, Biloxi, MS 39532 or 67186 Industry Lane Suite A, Covington, LA 70433.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected be federal or state law.

Patient's Name:_____DOB:_____

_____ _____
Patient/Legal Representative Signature Date

If signed by Legal Representative, relationship to patient;_____