AMERICAN ACADEMY™
OF OPHTHALMOLOGY

Ethics Committee Record Release Form
Authorization to Use and Disclose Health Information

I, _____, (date of birth: _____) authorize:
(name and address of ophthalmologist)

_____
_____
_____
_____

(hereafter called the "practice"), to provide a complete copy of my medical record in her possession to the Ethics Committee of the American Academy of Ophthalmology at the address printed above. I understand that the copy of my medical record will be used to evaluate my submission to the Ethics Committee.

I understand that I may revoke this authorization at any time by sending a letter to the medical practice stating our desire to cancel this authorization. I understand that if the medical practice has already sent a copy of my medical record to the Ethics Committee, it will not be able to retrieve the copy from the Ethics Committee.

I understand that I am not required to sign this authorization as a condition for obtaining continued treatment from the medical practice.

I understand that once the Ethics Committee receives my medical record, it may find it necessary to disclose information contained in it to others. If the Ethics Committee does find it necessary to disclose information from my medical record to others, it may no longer be protected by federal privacy rules.

By signing below, I acknowledge that I have read and understand this authorization form. A copy of this authorization form shall be as valid as the original. This authorization shall expire one year from the date written below.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (if needed) Date

Jan 2016