Triad Eye Center

Authorization to release PHI (Personal Health Information)

(EXCLUDES PHYSICIANS & ATTORNIES)

I hereby authorize Triad Eye Center to release my PHI to:

Please list name of person(s) that information may be released to
(ex. spouse, parent, siblings, etc.)

Patient's Printed Name:

Signature:

Date of Birth:

Witness:

To revoke this authorization, it must be submitted in writing to Triad Eye Center.

There is potential for re-disclosure once this information is disclosed. TEC cannot control what the other entity does with your PHI (Personal Health Information).