VENTURA ophthalmology

Bryant J. Lum, M.D.
Board Certified Eye M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

*Patients Name:*_____

In accordance with Federal government privacy rules implemented through the Heathcare Portability Act of 1996 (HIIPA), in order for your physician or staff of Ventura Ophthalmology Medical Group, Inc. to discuss your condition with members of your family or other individuals that designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to severity of your medial condition, the law stipulates that these rules may be waived.

_____ *I authorize Ventura Ophthalmology Medical Group, Inc. to release any and all information concerning my medical care & billing to the following individuals.*

_____	_____
Name	*Relationship to patient*
_____	_____
Name	*Relationship to patient*
_____	_____
Name	*Relationship to patient*

_____ _____

Patient Signature *Date*