HERSCHEL LASIK

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize HERSCHEL LASIK to discuss my medical conditions and information with anyone whom is listed below:

Print Name	Relationship	Telephone #
_____,	_____	_____
_____,	_____	_____
_____,	_____	_____
_____,	_____	_____

PATIENT SIGNATURE	Date of Birth	Today's Date
_____	_____	_____

_____

WITNESS

This information will remain in effect for twelve (12) months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at any time. This information is disclosed under Florida State Statute 395.3025.

Special Consent: I also authorize the release of the following information:
The release of information regarding my HIV, AIDS or AIDS-related status under State Law 381.004, to the person/institution named above.
The release of drug or alcohol abuse information as per Federal Statute 42 CFR, CH. 1, Part 2, (1983): and State Statute 397.501 to the person/institution named above.
The release of information regarding my mental health under State Statute 394.4615.

The above signed hereby releases the above named institution from any liability that may arise from the release and/or examination of the information indicated above. I understand that there will be a charge for copies and record review and that such a charge must be paid prior to review or release of my copies. Charge will be $1.00 per page up to $25.00, then $0.25 per page after that will be charged to the patient.

This information has been disclosed to you from records whose confidentiality is protected by Federal (42 CPR, Part 2) and State Law. These laws prohibit you from making any further disclosure of such information without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations.

Mark K. Herschel, M.D. 1911 N. Mills Avenue