Authorization to Release Health Information to Patient
Mary M. Varn, MD, LLC

MMV # _____

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____ Last four digits of SS # _____

City, State, Zip _____ Phone # _____

Email: _____

Name & address of Covered Entity authorized to release information:

Mary M. Varn, MD, LLC
233 East Blackstock Road, Suite J
Spartanburg, SC 29301

Phone: (864) 587-9872
Fax: (864) 587-9892

Forward information to:

Parent/Legal Guardian Name _____

____ Pick up

____ Fax Fax # _____

____ Email _____ @ _____ . _____

____ Mail ***Mailing Address _____

____ Prisma Pediatric Ophthalmology
200 Patewood Drive, Suite A200
Greenville, SC 29615
Phone: (864) 454-5540
Fax: (864) 454-5545

****A payment of $10 to cover processing/postage must be received prior to processing mail requests****

The information below will be released by patient request. (Description of PHI needed)

Last eye exam, last dilated eye exam, any operative notes and any other notes felt pertinent to patient's eye care_____

This authorization shall be in effect until the information has been released as requested.

Rights of the Patient:

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Mary M. Varn, MD, LLD, 233 East Blackstock Road, Suite J, Spartanburg, SC 29301.

_____ _____
Printed Name of Patient or Legal Guardian/Representative Relationship if not patient/parent

X_____ _____
Signature of Patient or Legal Guardian/Representative Date

Document(s) of patient representative's authority must be attached if patient/parent is not signing.