Authorization for Use and/or Disclosure of Confidential Information

EYE PHYSICIANS P.C.
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PLEASE PRINT **** INDICATES A REQUIRED FIELD***

*** Patient Name:**_____ ***Date of Birth:**_____

*** Address:**_____

Previous Name (if applicable):_____ ***Telephone #:**_____

**** THIS WILL AUTHORIZE (Provider name & address):***

Name:_____

Address:_____

_____

Fax Number:_____

**** TO DISCLOSE TO:***

Name:_____

Address:_____

_____

Fax Number:_____

**** THE FOLLOWING INFORMATION:***

[ ] Records from the last 1, 2 or 3 years (circle one)

[ ] Complete copy of the medical records

[ ] Other:_____

_____

**** FOR THE FOLLOWING PURPOSE:***

_____

_____

_____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. I authorize the release of this information, specifically: [ ] HIV Testing and Results; [ ] Mental Health Information; [ ] Alcohol, Drug or Substance Abuse Treatment.

Expiration: **This authorization is valid for 180 days from the date of signature, or until _____.**

Revocation: **I understand that I may revoke this authorization at any time by notifying the above named provider. I understand that if I revoke this authorization, any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Treatment, payment, enrollment or eligibility for benefits can not be conditioned on whether I sign this authorization for disclosure.**

Re-disclosure: **I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law and the recipient of your health information may potentially re-disclose it. However, under Federal Law, the recipient may be prohibited from disclosing identifiable substance abuse information.**

_____ _____
*** Signature of Patient of Legal Guardian** *** Date**

_____
*** Relationship to Patient if Not the Patient**

FOR OFFICE USE ONLY
Copied by:_____ Date:_____
[ ] To be sent • Sent on:_____
[ ] To be picked up on:_____
[ ] Picked up on:_____
Released by (Initials):_____
Released to:_____