Authorization for Use and/or Disclosure of Confidential Information

EYE PHYSICIANS P.C.

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 or 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:____________

RELEASE 8/2017