AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____Birthdate_____

Address_____

City_____State_____ZipCode_____

Phone Number_____ Alternate Number_____

I authorize the Eyesight Center/Neo Vision to: **OBTAIN** **RELEASE**

Information from/to: _____

Address: _____

Information to be released: Service Dates:_____

Purpose for the release:_____

1. Entire medical record
2. Allergy list
3. Discharge summary
4. History and physical
5. Laboratory results
6. X-ray results
7. Referral and consultation notes
8. OR report
9. Other:

Information on sexually transmitted disease, acquired immunodeficiency syndrome, human immunodeficiency, behavioral or mental health services and treatment for alcohol or drug abuse can be in medical records. This information may be released.

I understand that I have a right to revoke this authorization at anytime and that I must put that in writing, and present that request to the Privacy Officer or the Administrator of my facility who will deliver it to the Privacy Officer. I understand that the revocation will not apply to the information that has already been released, nor to information that is required by law by my insurance company. This revocation will expire in six months from the date or earlier as I have here: Month:_____Day_____Year_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may see or copy the information to be disclosed. I understand once my information is disclosed it may not be protected by the same high confidentiality standards as required by HIPAA and enforced by this facility. I understand that any questions that I have concerning this can be answered by calling this facility's Privacy Officer.

_____ _____

Signature of individual or Legal Proxy Date

_____ _____

Proxy Relationship to individual Date

_____ _____

Signature of Witness Date