Authorization for Use/Release of Health Information

TO: _____

Name of Physician or Organization requesting records from:

ADDRESS:_____

City **State** **Zip**

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize Eye Physicians & Surgeons, PC to obtain the protected health information described below. This information should be mailed or faxed to:

Eye Physicians & Surgeons, P.C. FAX #: (404)294-9361
1457 Scott Blvd.
Decatur, GA 30030

Please send this information on or about (information will not be resent without another authorization): ___/____/____
This authorization expires upon fulfilment of request unless special circumstances noted below **** Mo Day Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):_____

I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/____ to ___/___/____
Mo Day Year Mo Day Year

___ Copies of the information described below for period ___/___/____ to ___/___/____

___ History & Physical Examination ___ Lab, X-ray, etc. Reports ___ Reports from Other Physicians

___ Other (Please Specify)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during dates above –
_____

**** Please describe any special requirements such as Faxing, certified mail, extended expiration date, and the like –

_____

I understand that there may be information in these records that I would not want released.

I have been provided a copy of Eye Physicians & Surgeons, PC *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Eye Physicians & Surgeons, PC's Privacy Officer or other appropriate office personnel.

I understand that Eye Physicians & Surgeons, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Eye Physicians & Surgeons, PC from all legal liability that may arise from this authorization.

Patient's Signature _____**Date** _____

Print Patient's Name _____

SS# _____ DOB:_____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the patient is: _____. Signed _____

The patient or their representative may revoke this authorization by notifying in writing Eye Physicians & Surgeons, PC's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.