Authorization for Use/Release of Health Information

(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 use, release or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be Sent
Address of Person/Organization to Whom Information Should Be Sent
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 <i>not</i> 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 <i>Notice of Privacy Practices</i> 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 SignatureDate
Print Patient's Full Legal Name
DOB:Phone #
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.