The EyeClinic
Diseases & Surgery of the Eye

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____

I hereby authorize:
Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
to release to:
Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

□ A complete copy of my medical record
□ Specific information as described: _____
_____

The purpose of this Authorization indicated next to the box(es) below. Place an "X" on the box(es) that apply.

□ Further Medical Care □ Personal □ Legal Investigation or Action
□ Changing Physicians □ Research related treatment
□ Create health information for disclosure to a third party
□ Other: (Specify) _____

Revocation: I hereby acknowledge that I may revoke/withdraw this authorization at any time by providing written notification to the authorized recipient of these records and/or to the Medical Records Dept./Release of Information Department. I understand that the revocation/withdrawal will not apply to information that has already been released in response to this authorization. I also understand that the revocation/withdrawal will not apply to my insurance company or any entity for services already rendered.

_____ _____
Patient's Signature **Patient's Name (Print)**

_____
Signature of Parent, Legal Guardian, Power of Attorney, etc. if patient is a minor or incapable of printing/signing name

Print: _____ **Relationship**_____

_____
Patient's Mailing Address

_____
City/State/Zip Code

_____ _____
Patient's Date of Birth **Social Security #**

Patient's Ph# Home_____ **Cell**_____ **Work**_____

Expiration: This authorization expires one year from the date above, unless specified as follows:
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N**otes/Additional Information**:_____
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