ATLANTIS EYECARE

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient Authorization for Disclosure of Protected Health Information Form 7.31
This authorization allows the healthcare provider(s) named below to release confidential medical information records.
Note: *Information and records regarding treatment of minors, HIV psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorizations*.

Please print all information. Form must be signed and dated each year.

AUTHORIZATION:
I hereby authorize: _____ to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

Physician/Healthcare Facility Name

Patient Name:_____ **Date of Birth:** _____/_____/_____

Address: _____

City:_____ **State:** _____ **Zip:** _____

Entity Requested to Release Information:

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity that is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

❑ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results
- ☐ X-rays;
- ☐ Financial history report (previous 3 years only).
- ☐ Only send the following: _____
- ☐ other outside physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment pathology reports ?

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (please specify):_____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Representative Signature Date

You have the right to receive a copy of your signed authorizations upon request.