

CONFIDENTIAL

Authorization for Disclosure of Protected Health Information (Medical Records Release)

In order to provide for your healthcare, our practice collects information about your medical history, physical examinations, test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes not related to your treatment, receiving payment, or healthcare operations. This authorization gives our practice permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that there is a charge of \$5.00 for records exceeding 25 pages to assist with administrative costs, if I request records to be sent to myself.

Patient: _____ DOB: _____ Last 4 digits of SS #: _____

Address: _____ City/State/Zip: _____

I, _____ consent to the disclosure of the following information:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Dictated notes | <input type="checkbox"/> MRI | <input type="checkbox"/> Telephone call forms | <input type="checkbox"/> Fundus photos |
| <input type="checkbox"/> Office notes | <input type="checkbox"/> Lab reports | <input type="checkbox"/> Billing history | <input type="checkbox"/> Visual fields |
| <input type="checkbox"/> Fluorescein angiography | <input type="checkbox"/> Electrocardiograms | <input type="checkbox"/> All clinic records | <input type="checkbox"/> Other (specify) |

For the following dates: _____ Since _____ All Records

I hereby give special permission to release otherwise privileged information pertaining to the following:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> AIDS Test results | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> AIDS-Related disease diagnosis | <input type="checkbox"/> Drug abuse |

Purpose or need for disclosure:

- | | | |
|---|--|---|
| <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Further medical care |
| <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal investigation | <input type="checkbox"/> Employer update |
| <input type="checkbox"/> Vocational rehabilitation evaluation | <input type="checkbox"/> Disability determination | |

Release Record(s) To The Following:

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

Comments:

Phys. Approval _____
Privacy Officer _____
Date _____

Records copied by: _____ Faxed or mailed by: _____ Date: _____

Blue: Privacy Officer Pink: Send with records or send to patient Green: Chart