**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name_____ Date of Birth_____ Last four SS#_____

Address of Patient_____City_____State_____Zip_____

I authorize _____ to release information from my health record for the purpose of

**(Please Circle all that apply)** Continuation of care Changing Doctors Moved Copy for personal use

**I would like the following information released to (Entity Name):_____**

**Address_____Fax #_____**

**(Circle all that apply)** Complete medical record Last office visit All Photos and Imaging Results
Dictated letters Operative Reports Labs/Radiology

**I authorize release of information regarding (circle all that apply)**

Mental Health Information Drug or Alcohol Abuse Information

*****HIV-related information contained in the parts of the record will be released through this authorization unless otherwise indicated.** (Please circle your choice) Release Do not Release

**I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No, time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending written request to the entity/person that I authorized above to release the information. If applicable please specify other expiration date here._____.**

_____ _____
Patient Signature Date of Signature

_____ _____
Witness Signature Date of Witness Signature

| | | |
|---|---|---|
| **Patient offered a copy of this authorization** | **Yes** | **No** |
| **Patient wanted a copy of this authorization** | **Yes** | **No** |
| **Patient refused copy of this authorization** | **Yes** | **No** |

## Additional Patient Rights and Responsibilities

- **A disclosure statement is required by law, will accompany all records released.**
- **Release of my records will be for the purpose stated on this form. Only those items circled will be released.**
- **Although applicable law may prohibit re-disclosure of these records. I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore Retina and Macula Consultants and its staff/employees have no responsibility or liability as a result of any re-disclosure and such would no longer be protected by the (HIPPA) Privacy Rule, however, such information is always protected by the drug and alcohol regulations.**
- **My decision to revoke the Authorization does not apply to any release of records that may have taken place prior to the date of my revocation of the Authorization.**
- **Retina and Macula Consultants cannot require me to sign the Authorization in order to receive treatment.**
- **In accordance with the law, Drug and Alcohol treatment information can be released to judges, probation or parole officers, insurance companies, health or hospital plan or governmental officials shall be restricted to the following: 1) Whether the client is or is not in treatment. 2) The prognosis of the client. 3) The nature of the program. 4) A brief description of the progress of the client. 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and frequency of such relapse.**
- **A verbal request to revoke this authorization is not sufficient for information protected under the drug and alcohol regulations**
- **I am entitled to a copy of this completed Authorization form.**