ASSOCIATED EYE CARE

Authorization for Release and Request for Medical Information

I hereby authorize and request to furnish the protected health information of:

Name of Patient (Please Print): _____
Last First MI

DOB:_____ **Social Security #**_____ **Phone Number**:_____

Address: _____
Street City State Zip Code

I. My Authorization

You may use or disclose the following health care information (check all that applies):

❒ All my health information.

❒ Other:_____

Reason for this authorization:

❒_____

Release Records FROM:

Name: _____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____

Send Records TO:

Name: _____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____

***ALL photos and scans must be mailed or emailed in color to preserve quality**

II. My Rights

- I may refuse to sign this authorization and my refusal will have no impact on receiving treatment.
- I can inspect or copy any information disclosed under this agreement
- I have voluntarily signed this document
- I can revoke this authorization at any time and the revocation must be in writing.
- I understand that the revocation will not apply to information that has already been released.
- I will receive a copy of this authorization if requested.
- The federal privacy laws will not cover the information released.
- Copies of the records may be obtained with reasonable notice and payment of copying cost.
- I understand this authorization will expire one year from date it was signed.

I have carefully read and understand the above, have had any question explained to my satisfaction, and do herein expressly voluntarily authorize disclosure of the above information about or medical records of my condition to those persons or agencies listed above.

_____ _____

Patient or legally authorized individual signature **Date**