

CONFIDENTIAL Authorization for Disclosure of Protected Health Information

(Medical Records Release) Received in office by: _____ Date: _____

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 non 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 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.

Patient _____ (PRINT) D.O.B. _____

Address _____

Therefore I, _____ (SIGN) consent to the disclosure of the following:

- | | | |
|-------------------------|--------------------|----------------------|
| Dictated notes | MRI | Telephone sheets |
| Office notes | Lab reports | Billing history |
| Fluorescein angiography | Electrocardiograms | All clinical records |
| Fundus photos | Visual fields | Other (specify) |

For the following Dates: _____ Since _____ All _____

Purpose or need for Disclosure:

- | | | |
|----------------------------------|--------------------------------------|----------------------|
| At the request of the individual | Application for insurance | Further medical care |
| Payment of insurance claim | Legal investigation | Employer update |
| Disability determination | Vocational rehabilitation evaluation | |

Release to (name): _____
Address: _____
Phone #: _____
Fax #: _____

Dr. Approval: _____
Date: _____
**PLEASE TAG
RECORDS TO SEND!**

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