AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Name (PRINT): _____ SS#: _____ DOB:_____

is requesting that Central Ohio Eyecare, Inc. release health information (check one):

☐ **TO *or* obtain** ☐ **FROM the person/company/agency/facility listed below.**

Name, Position, or Department:	
Name of Organization:	
Address of Organization	
Phone # of Organization:	
Fax # of Organization:	

The information to be disclosed relates to service dates beginning _____ and ending _____.

□ Entire Medical Record	□ Medication List	□ Physician Office Visits
□ Demographic Information	□ Immunizations	□ Discharge Summary
□ Medical/Surgical History	□ Test Results	□ Other: (specify)

The purpose of the disclosure: ("Request of individual" is sufficient for patient initiated releases)

□ Request of Individual	□ Change of Doctor	□ Legal Investigation
□ Referral to Specialist	□ Insurance	□ Other: (specify)
□ Continuing Care	□ Workers Comp	

CONDITIONS AND NOTIFICATIONS:

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Manager at the address listed above. However, such notification will not affect any actions in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the Central Ohio Eyecare, Inc. practice identified above.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____Date: _____
PRINT Name of Patient/Personal Representative: _____
Relationship of Representative to Patient: _____

Released by: _____ Date: _____
(Department Representative Name)