# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**PATIENT NAME:** _____

**DATE OF BIRTH:** _____ **PHONE #:** _____

**ADDRESS:** _____

**CITY/STATE/ZIP:** _____

Due to HIPAA regulations, we are no longer allowed to release any information regarding your medical condition, diagnosis, treatment, or prognosis to any person without your consent.

**I request to release my information:** ☐ **To** ☐ **From**

**Graystone Eye Medical Records**
P.O Box 2588
Hickory, NC 28603
Phone: (828) 322-2050
ext. 6763 or 6722
Fax: (828) 324-4271

**Release to or request my information from:**

**Name of Provider and Practice:** _____

**Phone number:** _____ **Fax number:** _____

**Address:** _____

☐ **All Records** ☐ **Specific dates of care:** _____ **to** _____

**By signing this release below I acknowledge and understand the following:**

- I have the right to inspect or obtain a copy of the protected health information described by this authorization, upon my written request.
- Graystone Eye will not condition treatment, payment, or (if applicable) enrollment in a health plan/benefit option based on my providing authorization for the requested use/disclosure of information.
- I may refuse to sign this authorization, but know that without a signed release, my records cannot and will not be released on my behalf.
- I may revoke this authorization in writing at any time by delivering such written revocation to Graystone Eye, such revocation will not be effective as to the disclosure of records authorized prior to written notice.
- Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

**COPY PROVIDED:** Graystone Eye shall supply a copy of this signed authorization upon your request. This information will be disclosed to you, from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent to which it pertains. State law requires the individuals authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of my specified medical information listed above to the receipent(s) listed above. I understand that this may include information pertaining to my HIV status, records of mental health care and treatment, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

**Patient Signature:** _____ **Date:** _____

**Printed Name Of Patient Or Authorized Representative:**_____

**Witness Signature:** _____ **Date:** _____

THIS RELEASE IS GOOD UNTIL REVOKED BY THE SIGNING PATIENT