

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION



Patient Name: _____

Date of Birth: _____ Phone Number: _____

Mailing Address: _____

The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY AND DOCTOR	NAME OF PERSON/ORGANIZATION/FACILITY/DOCTOR
ADDRESS	ADDRESS
FAX NUMBER	FAX NUMBER
PHONE NUMBER	PHONE NUMBER

1. The purpose or need for this disclosure is: (check appropriate boxes)

- Continuity of Medical Care
 Attorney
 School
 Personal Use
 Insurance
 Disability
 Other (Specify): _____

2. The information to be disclosed from my health record: (check appropriate boxes)

- Specific dates of care: _____
 Only information related to: _____
 Other (Billing, Images, etc.): _____
 Entire Record

3. Please release my records in the following format:
 Electronic Copy
 Paper Copy

If you would like your records electronically, please specify format:

- Secure Email (Provide email address): _____
 Patient Portal
 Other (Please list) : _____

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 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. 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.

Patient Signature: _____ **Date:** _____

Printed Name Of Patient Or Authorized Representative: _____

Witness Signature: _____ **Date:** _____