AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ D.O.B._____ MR#_____

I give my permission to share my protected health information. Please enter where you would like information sent from and to whom you would like the information sent to.

**From:**

Name: _____

Address: _____

_____

Phone: _____Fax: _____

**To:**

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

**Purpose:** ❑Medical Care ❑ Insurance ❑Legal Matter ❑Personal ❑School ❑Transfer of Care

**Information to Be Disclosed:**
I authorize disclosure of the following information:

- ❑ Medical Record Abstract/dates_____ (e.g., History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ❑ Billing Records
- ❑ Cardiology Records
- ❑ Emergency Room Records
- ❑ Laboratory Reports
- ❑ Office Notes
- ❑ Operative Reports
- ❑ Pathology Reports
- ❑ Radiology Images on CD
- ❑ Radiology Reports
- ❑ Radiation Reports
- ❑ Rehab Services
- ❑ Other (please specify below)

_____

❑ Records for specific dates: _____ to _____

**Sensitive Information to Be Disclosed:**
Please check **YES** to indicate if you give permission to release the following information if present in your record:

- ❑ YES **HIV/AIDS Related Test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) **SPECIFY DATES** _____
- ❑ YES **Genetic Screening test results** (SPECIFY TYPE OF TEST) _____.
- ❑ YES **Alcohol and Drug Abuse Treatment Records** Protected by Federal Confidentiality Rules 42CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2). This consent may be revoked upon oral or written request.
- ❑ YES Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may not be required to release my mental health records for payment purposes)* **(EXCLUDES PSYCHOTHERAPY NOTES)**
- ❑ YES Confidential communications with a Licensed Social Worker
- ❑ YES Details of Domestic Violence Victims' Counseling
- ❑ YES Details of Sexual Assault Counseling

**Format of Records:** ❑ Paper (or other physical) copies ❑ Electronic (Thumb drive)
There may be a charge for copying and shipping records. I will be notified of the cost prior to receiving/sending records.

**Method of Delivery:** ❑ Mail to receiving entity above ❑ I will pick up
❑ Designee will pick up (specify below) ❑ Other _____ Patient

Name_____ D.O.B._____ MR#_____

*To be completed if Designee will pick up records:*

I allow _____ [print name], my designee, to pick up the medical records identified above since I am unable to do so myself.

- ❑ One time only − once my designee picks up my medical records, that person may not pick up my medical records in the future unless I sign another copy of this document.
- ❑ Indefinitely − my designee may pick up my medical records until I revoke the authority of my designee or until this PHI Release form expires or is revoked by me.

- I MAY REFUSE TO SIGN THIS AUTHORIZATION. Eyesight Ophthalmic Services, P.A., Clear Advantage Vision Correction Center, and its related entities, will not refuse to treat me based on my refusal to sign the Authorization unless the sole purpose of the requested treatment is to create records for disclosure to someone else. For example, the Hospital may refuse to perform a pre−employment physical for me if I refuse to authorize the release of information obtained during that physical to my employer.
- I may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to: **Eyesight Ophthalmic Services, P.A., ATTN: Office Manager, 155 Borthwick Ave, Ste 200E, Portsmouth, NH 03801-7156.** If you are a lasik patient, please send your request to: **Clear Advantage Vision Correction Center, 155 Borthwick Ave, Ste 200E, Portsmouth, NH 03801-7156.**
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.
- I understand that I have the right to inspect or receive a copy of the information I am consenting to release within the established policies of Eyesight Ophthalmic Services, P.A., Clear Advantage Vision Correction Center, and its related entities.
- This authorization will automatically expire **12 months from the date signed** unless limited to the following date/event

  _____.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature of Patient or Legal Representative/Guardian **(Legal Handwritten Signature Accepted Only)** | Date |

_____

Authority or Relationship of Representative *(Attach copy of documentation of authority)*

AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508.
A copy of this authorization must be provided to the patient.

***For Office Use Only:***
Request Processed and Records Sent with Patient By: Staff Initials_____ Date_____

***For Medical Information use only:***
❑Patient picked up ❑Mailed to patient ❑Mailed to receiving entity ❑Other_____ Date: _____

Completed By: Staff Initials_____ Date_____

❑***A copy of this signed authorization has been included with the records provided to the patient.***

***For Designees/Patients picking up records only (signature will be obtained by Medical Information at time of pick up):***

Signature _____ Printed Name _____ Date_____