Eyesight Uncompromising Care

Clear Advantage Vision Correction Center

**Please mail or fax to:**
**Eyesight Ophthalmic Services**
**267 Route 108**
**Somersworth, NH 03878**
**Fax: 603-692-7575**

## AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

### A. PATIENT INFORMATION

Patient name: _____ Patient date of birth (DOB): _____

Patient Address: _____ Apt /Unit #_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email:_____

### B. PERMISSION TO SHARE: I give permission to share my protected health information (PHI).

***Enter where you would like information sent from, and to whom you would like the information sent to.***

**FROM:**

**Eyesight Ophthalmic Services, PA**
**267 Route 108**
**Somersworth, NH 03878**
**P: 603-692-7500 F: 603-692-7575**

****Copying fees may apply**
**Please check below format of records**

- ☐ 1 Visit - Free of charge (paper)
- ☐ 2+ Visits - $15 flat rate (paper)
- ☐ Doctor to Doctor- Free of charge
- ☐ Patient Portal - Free of charge
  *(Please provide email address in section A above)*

***Release will be processed once payment is received.***

**TO:** (e.g. to whom you would like the information sent)

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent.

NAME: _____

ADDRESS: _____

_____

Telephone: _____Fax:_____

Send by

Mail ☐

Fax ☐

Pick Up in Office: ☐ Please indicate which office:

☐ Portsmouth ☐ Somersworth ☐ Exeter ☐ Kittery

### C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates)

**Medical Records from _____to _____** ***(specific dates)***

☐ **Diagnostic Testing** ☐ **Operative Reports** ☐ **Pathology Reports**

**Other:**_____***(please specify)***

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**D. I understand and agree that:**

- I may refuse to sign this authorization. Eyesight Ophthalmic Services, PA, 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 in making a disclosure. Your written revocation will be come 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 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**
  **Attn: Medical Records Dept**
  **267 Route 108**
  **Somersworth, NH 03878**

- 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 a right to inspect a copy of the information I am consenting to release within the established policies of Eyesight Ophthalmic Services, PA.

- This Authorization will automatically expire 12 months from the date signed unless limited to the following date/event

_____ _____

**Signature of Patient or Legal Representative/Guardian** **Date**
*(Handwritten signature accepted only)*

FOR OFFICE USE ONLY:

Request Processed by_____ (Initials) Date processed _____

Medical Record#_____