The TOTAL EYE CARE TEAM

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PURPOSE OF THIS DISCLOSURE:		PHONE
PATIENT NAME (Last, First, Middle)		DOB
ADDRESS		SSN
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:		
	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	ATTENTION:		
This authorization will expire on the following date or event	DATE	EVENT	

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
❑ All PHI in the record		
❑ Progress Notes		
❑ Laboratory Tests		
❑ X-Ray Tests/Reports		
❑ History and Physical Examination		
❑ Consultation Reports		
❑ Itemized Billing Statement		
❑ Other:		

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment,enrollment or eligibility benefits may not be a conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	Date
Signature of Patient's Representative (if necessary)	Date
Personal Representative's Relationship to Patient	