Avery Eye Clinic
phone: 936-539-4500 fax: 936-539-1216
P.O. Box 2648
Conroe, Texas 77305

Authorization to Disclose Private Health Information "PHI"

Release To/From: Patient, Family Member, Physician, Entity, Facility, Representative:

FROM: _____ Release To: _____

_____ _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Patient Name: _____ Date of Birth: _____ Chart # _____

By signing below I hereby authorize the disclosure or use of the above named individual's health information in accordance of the Medical Privacy Act of Texas from the Individual or organization described below for the disclosure and use of Avery Eye Clinic.

MAPLE AVERY,M.D. BAPTISTE DEJEAN,M.D. CRAIG KUGLEN,M.D. GURPREET SINGH, M.D

Reason or purpose of disclosure or release:

_____ Patient and or authorized representatives request
_____ Continuance of Medical care
_____ Other: _____

Items to be disclosed are as follows:

_____ Entire Chart
_____ Medical records dated from _____
_____ Correspondence
_____ Insurance Notes
_____ Other: _____
_____ Financial Information
_____ Diagnostics
_____ Surgical notes
_____ Contact Lens RX / Glasses RX / notes

_____ I understand that the information disclosed may contain information regarding HIV or sexually transmitted disease and or mental / behavioral health services information and / or drug abuse/alcohol use.

Right To revoke PHI after the date of April 14, 2003: I understand that I decide to revoke this authorization to release PHI, I have to send a written request to the Avery Eye Clinic Privacy Officer to the following address.******Privacy Officer, P.O. Box 2648, Conroe, Texas 77305.
I understand that a revocation is not effective to the extent that Avery Eye Clinic has relied on this authorization is its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPPA Privacy regulations. Avery Eye Clinic will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.
Unless revoked this authorization will be in force and until the following date: 6 years or event occurs (describe event or write "not applicable"). _____

_____ _____
Signature of Patient/Guardian/Legal Representative Print Name of Patient/Guardian/Legal Rep.

_____ _____
Date Description of Representative (e.g. court order, lawyer)

_____ FOR MARKETING PURPOSES – I understand that the person I am authorizing to use and / or disclose information for marketing purposed will receive either direct or indirect compensation for doing so.

Avery Eye Clinic