Avery Eye Clinic

Board-Certified Medical and Surgical Ophthalmologists
Fellows of the American Academy of Ophthalmology

Baptiste J. Dejean, III, M.D., F.A.C.S.
Craig C. Kuglen, Jr., M.D.
Linda H. Lin, M.D.
Mark H. Wilkerson, M.D.

Brian C. Au, M.D.
Andrew W. Dvorak, M.D.
Renee E. Williams, O.D.

Authorization to Disclose Private Health Information

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

FROM:____
____
____
Phone: ____
Fax: ____

TO:____
____
____
Phone: ____
Fax: ____

Patient Name: __________________________ Date of Birth: _____________ Chart#: _____________

Reason or purpose of disclosure or release:
_______ Patient/authorized representatives' request
_______ Continuance of Medical care
_______ Other:__________________________________

Items to be disclosed are as follows:
_______ Entire Chart _______ Financial Information
_______Medical records dated from___________
_______Diagnostics _______Surgical Notes
_______Correspondence_______Insurance Notes
_______Contact Lens Rx/Glasses Rx/Notes
_______Other:__________________________________

_______ 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: I understand that I may revoke this authorization to release PHI by sending a written request to:
Avery Eye Clinic Privacy Officer, 400 S. Loop 336 W., Conroe, TX 77304.
I understand that a revocation is not effective to the extent that Avery Eye Clinic has relied on this authorization for its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as law provides the insurer with the right to contest a claim under the policy itself. I understand that information pursuant to this authorization may be subject to re-disclosure 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 until the following date: 6 years or event occurs
*describe event or write "not applicable"*____

____
Signature of Patient/Guardian/Legal Representative

____
Printed Name of Patient/Guardian/Legal Representative

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

____
Date

_______*For Marketing Purposes: I understand that the person I am authorizing to use and/or disclose information for marketing purposes will receive direct or indirect compensation for doing so.*

_______*Medical Records Fee of $25*