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

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Authorization to Disclose Private Health Information

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

FROM:______________________________________ TO:______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Phone:______________________________________ Phone: ______________________________________

Fax: ______________________________________ 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*

_______***Medical Records Fee of $25***

_______*For Marketing Purposes Only: 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.*