



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

_____ 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

Conroe
400 South Loop 336 West
Conroe, TX 77304
(936) 539-4500

Huntsville
3361 Montgomery Road.
Huntsville, TX 77340
(936) 294-0218

Woodlands
129 Vision Park Blvd., Ste. 110
The Woodlands, TX 77384
(281) 719-5214