Patient Authorization for Release/Disclosure of Protected Health Information 7.31b

Please print all information, then sign and date form at bottom.

Patient Name: _____ Date of Birth: _____

Patient Address:_____

Purpose of request - I request and authorize West Metro Ophthalmology, PA to release or disclose my protected health information (as identified below) to the following:

_____
Name of practice / provider/ person /organization who will receive information

_____
Address

_____
City, State, Zip

_____ _____
Phone Fax Number

Description of information to be disclosed - I authorize the disclosure of the following protected health information about me to the provider identified above:

- ☐ Last Full Exam; **or**
- ☐ Complete medical record; **or**
- ☐ Exams for the following dates:_____through_____ **or**
- ☐ The following limited information (provide description): _____

_____

_____Please initial here if you prefer an electronic version (CD or Flash Drive) of your medical record.

Purpose of disclosure:

- ☐ Patient Request
- ☐ Other_____

- **Expirations or termination of authorization**: This authorization will expire one year from the date of your signature below unless you specify an earlier termination. We require a new authorization after the expiration date to continue the release of information.
- **Right to revoke or terminate**: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization at any time, except to the extent that action has already been taken in reliance upon it, by submitting a written request to our Privacy Manager.
- **Non-Conditioning statement**: West Metro Ophthalmology places no condition to sign this authorization on its' delivery of healthcare or treatment.
- **Redisclosure**: West Metro Ophthalmology has no control over the person or entity you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of West Metro Ophthalmology.

_____ _____
Patient signature Date

Copies of signed authorizations are available upon request. 5/2014