Patient Authorization for Release of Protected Health Information

Form 7.31a

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

Patient Name: _____ **Date of Birth:** _____

Patient Address:_____

I authorize _____

Address:_____**Fax:**_____

to provide protected health information, about me to West Metro Ophthalmology, PA:

☐ 5851 Duluth Street #215
Golden Valley, MN 55422
Phone: (763) 546-8422
Fax: (763) 546-8114

☐ 15655 37th Ave N #200
Plymouth, MN 55446
Phone: (763) 553-0288
Fax: (763) 553-0891

☐ 107 Center Drive #200
Buffalo, MN 55313
Phone: (763) 682-9241
Fax: (763) 684-1040

☐ 504 Pine Street
Monticello, MN 55362
Phone: (763) 295-0004
Fax: (763) 295-4701

I authorize the disclosure of the following protected health information about me:

☐ Complete medical record ☐ Contact Lens Information ☐ Fundus & Disc Images

☐ CT / MRI Reports ☐ CT / MRI Films

☐ The following limited information (provide description)_____

_____

Purpose of disclosure:

☐ Patient Request or

☐ Other_____

- **Expirations or termination of authorization**: This authorization will expire within one year from the date of your signature below unless you specify an earlier termination. You must submit a new authorization after the expiration day to continue the authorization.
- **Right to revoke or terminate**: You have the right to revoke or terminate this authorization at any time. You must contact the covered entity and find out the appropriate person to notify and appropriate procedure to follow. They may require that you submit a written request.
- **Non-Conditioning statement**: The entity disclosing your protected health information places no condition to sign this authorization on its' delivery of healthcare or treatment.
- **Redisclosure**: The entity you have authorized above to release your protected health information cannot prevent redisclosure. 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 their responsibility.

_____ _____

Patient / Guardian / Personal Representative Signature Date

Copies of signed authorizations are available upon request.

5/2014