CONFIDENTIAL Authorization for Disclosure of Protected Health Information

(Medical Records Release) Received in office by: ________________Date: ________________

In order to provide for your healthcare, our practice collects information about your medical history, physical examinations, test results, diagnoses and treatments. Use and disclosure of protected health information is regulated by a federal law known as **The health Insurance Portability and Accountability Act of 1996 ("HIPAA").** Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes non related to your treatment , receiving payment, or healthcare operations. This authorization gives our practice permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment), Except: to take part in research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

Patient____**(PRINT) D.O.B.** ____________________________

Address ____

Therefore I,________________________________**(SIGN) consent to the disclosure of the following:**

Dictated notes **Office notes** **Billing history** ***All clinical records**

Fundus photos **Visual fields** **Other (specify)**

For the following Dates:________________ Since ____________________ All________________

Purpose or need for Disclosure:

____At the request of the individual ______Further medical care

____Payment of insurance claim ______Disability determination

Release to (name): ______________________________________

Address: ______________________________________

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Phone #:______________________________________

Fax #: ______________________________________

Record copied by: ________________ Faxed or mailed by: ________________ Date: ________________