Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ Social Security #: _____

Eye Surgeons of Springfield, Inc.
1330 E. Kingsley
Springfield, MO 65804
417-887-1965 • Fax 417-887-6499

Purpose of Request

- ☐ Treatment or consultation
- ☐ At the request of the patient
- ☐ Billing or claims payment
- ☐ Other: _____

Information to be Released – Covering the Periods of Health Care

From: _____ *(date)* To: _____ *(date)*

From: _____ *(date)* To: _____ *(date)*

Please check type of information to be released:

- ☐ Pertinent documentation
- ☐ Complete health record
- ☐ Complete billing record
- ☐ Itemized bill
- ☐ Visual fields
- ☐ A/B scans
- ☐ Glasses prescription
- ☐ Contact lens information
- ☐ Angiograms
- ☐ Photographs
- ☐ X-ray reports
- ☐ History and physical
- ☐ Discharge summary
- ☐ Operative report
- ☐ Consultation reports
- ☐ Other

If Other, (specify) _____

I, the undersigned, authorize and request this medical facility to:

☐ **Release information to:** ☐ **Obtain information from:**

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquire Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization b submitting a notice in writing to the facility Privacy Officer at the above address. Unless revoked, this authorization will expire on th following date or event_____, or one year from date of signature, unless otherwise specified

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign thi form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Re quest. I can inspect or copy the protected health information to be used or disclosed. I authorize Eye Surgeons of Springfield to use an disclose the protected health information specified above.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that thos records are protected by Federal Law. The Authorization for Release of Information form does not authorize redisclosure of medica information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed fron records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as other wise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient fo these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient

Signature: _____
(Patient or legal representative) *Date*

Relationship to Patient: _____

Revised April 22, 2003

Identity of Requested Verified via:

___ Photo ID, Matching Signature

___ Other, specify _____

Verified by: _____