Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information and return to front desk. Form must be signed and dated each year.

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

Entity Requested to Release Information: _____

_____

_____

Purpose of request (who will be authorized to receive information)- I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Entity authorized to receive your information:

Premier Eye Group, 3130 Central Park West Suite 6544B, Toledo, Ohio 43617 Phone: (419)273-7400

Information to Share (Please check one option)

☐ All of my medical records maintained by this practice.

☐ Only the specific information checked below:

☐ Office Notes/Testing ☐ Lab results, pathology reports ☐ Financial history report

☐ nursing home, home health, hospice and other physician records

Reason for Sharing

☐ Patient request ☐ Other (Please specify): _____

Authorization Period & Patient Rights

Expiration: This authorization will expire in one year, unless I specify a different date: _____

Right to Revoke: I can cancel this authorization at any time by submitting a written request to your office. The cancellation will not apply to information already shared based on this form.

No Obligation: I understand that my treatment or payment is not conditional on signing this form.

Risk of Re-disclosure: I understand that once my information is shared, it may no longer be protected by federal privacy laws (HIPAA) and could be re-disclosed by the recipient.

Signature

By signing below, I confirm that I have read, understood, and agree to the terms of this authorization.

Patient or Representative Signature:

X_____ Date: _____

Printed Name: _____ Relationship to Patient: _____