ADVANCED EYE
CARE CENTER

Authorization Use or Disclosure of Health Information

Date Needed By ____/____/____ ☐ To be picked up ☐ To be mailed

PATIENT IDENTIFICATION

Name _____ Date of Birth ____/____/____

Address _____

City/State/Zip _____

Maiden/Previous Names/Nickname _____

Social Security Number _____

PROVIDER
Who is releasing Information

Provider/Facility Name _____ Phone _____

Address _____

City/State/Zip _____

DISCLOSE INFORMATION TO
Where is the information sent

Provider/Facility Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

To ensure confidentiality, it is Advanced Eye Care Center's policy to send reports via first-class mail. Advanced Eye Care Center will transmit records via fascmile only when requested and expressly authorized by the patient.

INFORMATION TO BE DISCLOSED

☐ Clinic progress notes ☐ Lab data ☐ All records

☐ Other _____

PURPOSE OF DISCLOSURE
Please be specific

☐ Continuing medical care ☐ Consult ☐ Out-of-town move

☐ Insurance claim ☐ Legal ☐ Personal

☐ Other _____

EXPIRATION

This authorization will expire one year from the date of signature on _____

REVOCATION

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

AUTHORIZATION

I hereby authorize the above facility/provider to disclose the medical information concerning the above named patient to the party identified in the section entitled *Disclose Information To*. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

Patient/Representative Signature _____ Date ____/____/____

Relationship to Patient (If signed by representative) _____

Witness (optional) _____

Please supply proof of authority to act. For minors, proof is only required if other than the parent.

DISPOSITION

For Office Use Only

Date Sent ____/____/____ Sent By _____

☐ Authority to act attached ☐ ID validated MR # _____