AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*****ENTIRE FORM MUST BE COMPLETED FOR RECORDS TO BE RELEASED*****

I authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of substance abuse, psychiatric/mental health information of HIV/AIDS information) of:

Printed Patient Name ______________________________ Date of Birth ________________

Patient Phone Number ______________________________ Alt Number ________________

Person/Organization Authorized to Release Information

____

Address______________________________

____

Phone______________________________

Person/Organization Authorized to Receive Information

____

Address______________________________

____

Phone ______________________________

I REQUEST THE FOLLOWING PROTECTED HEALTH INFORMATION

______ Exam notes for last two visits
______ Most recent diagnostic test/lab results
______ Entire medical record generated by Midwest Retina, Inc.
______ Other (please be specific) ______________________________

PURPOSE OF REQUEST

______ Continuity of Medical Care
______ Self
______ Legal Reasons
______ Transfer of Care
______ Insurance Billing
______ Military
______ Disability/SSI
______ Other (please be specific) ______________________________

I understand:

- This authorization shall be in force and in effect for one year from the date signed.
- Under the Ohio Revised Code, a copying fee may be charged for providing a copy of the requested medical record.
- I have the right to revoke this authorization, in writing, at any time by sending such written notification to Administrator at Midwest Retina, Inc. A revocation is not effective to the extent that Midwest Retina, Inc. has taken action based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I further understand that if the person or entity receiving information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations
- Midwest Retina, Inc. will not condition my treatment, payment or healthcare options on whether I provide authorization for the requested use or disclosure.

This authorization and request is fully understood and made voluntarily on my part. I release the above-named facility of any legal liability that may arise from release of the information requested.

Patient Signature______________________________ Date ________________

Printed Guardian/Legal Representative ______________________________ Signature ________________