Children's Eye Care and Surgery of Georgia

Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME: _____ DOB: _____

PERSON(S)/ORGANIZATION AUTHORIZED TO PROVIDE THE INFORMATION (include phone/address):

_____

PERSON(S)/ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION (include phone/address:

INFORMATION TO BE RELEASED:

(Check ALL that apply) Date(s)

- ☐ History & Physical Exam _____
- ☐ Office Visits _____
- ☐ Lab Reports _____
- ☐ X-Ray Reports _____
- ☐ Patient Medical Photos _____

Other _____ _____

I specifically authorize the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug use)
- ☐ Mental Health (including psychotherapy notes)
- ☐ HIV related information (including AIDS related testing)
- ☐ Genetic Testing

X _____
signature

PURPOSE OF DISCLOSURE:

☐ Changing Physicians ☐ Consult/Second Opinion ☐ Continuing Care
☐ Legal ☐ Other _____

This authorization will expire on _____ (NOTE: If left blank, it will expire 12 months from date signed).

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not healthcare provider, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

OFFICIAL USE ONLY:
INFORMATION RELEASED BY: _____ DATE RELEASED: _____