

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION



(MAY TAKE UP TO 15 BUSINESS DAYS)

KATZEN EYE GROUP

PATIENT INFORMATION:

(Name)

(Date of birth)

(Phone)

(Home address)

TO DISCLOSE TO:

Self: Pick up

Mail to address above

I hereby authorize _____ to pick up my medical records (Photo ID required)

Health Care Provider/ other

(Name and address of Health Care Provider)

(Phone number)

(Fax number)

We cannot release records via email due to HIPPA standards

We will not re-disclose any records from your previous physician/physician's office

DATE(S) OF INFORMATION TO BE DISCLOSED:

From (month/year) _____ To (month/year) _____ Entire Record

If left blank, only information from the past (2) years will be disclosed.

PURPOSE: (Check all that apply- ***Copy fees may apply***)

- | | |
|---|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Legal Investigation/ Action |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Personal (at my request) |
| <input type="checkbox"/> Other: _____ | |

Effective Date of Termination of this Authorization: _____

I understand: I have the right to receive a copy of the health information which I've authorized to be used/disclosed through this document. There may be a charge for medical record copies. In addition, I do not need to sign this form in order to receive treatment. I may revoke this authorization by notifying the disclosing medical records/health information department in writing. However, my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) the need for an insurer to file a claim/policy as authorized by law if signing the authorized may be a subject to re-disclosure and may no longer be protected by federal law.

If signed by a person other than the patient, check the following:

1. Individual is:
 - A Minor
 - Legally incompetent or incapacitated
 - Deceased

 2. Legal Authority
 - Parent
 - Legal Guardian
 - Next of kin/executor of deceased
 - Activated POA for Health Care
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