SMYRNA EYE GROUP, P.C.
Excellence In Eye Care

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME:_____BIRTHDATE:_____

ADDRESS:_____ CITY:_____ ZIP CODE:_____

SOCIAL SECURITY:_____ PHONE NUMBER:_____

I authorize Smyrna Eye Group, P.C. to (select one):

- ☐ Disclose my protected health information TO:
- ☐ Request copies of my protected health information FROM:

_____

Office or Dr.'s Name Mailing Address

_____

City State Zip

*If address is incomplete, requested information will be mailed to patient.

Specifically covering treatment from (specify dates or event):_____ to:_____

Purpose of use and/or disclosure of protected health information:_____

_____

Please specify the type of information to be used and/or disclosed:

- ☐ Exam Copies, Tests and Results
- ☐ Exam Notes or Summaries
- ☐ Tests/Results (Please Specify):_____
- ☐ Prescription of Glasses and/or Contact Lenses
- ☐ Other (Please Specify):_____

This authorization is valid for six (6) months after the date it is signed

RIGHTS

- ★ I have a right to receive a copy of this Authorization.
- ★ I have a right to revoke this authorization at any time by submitting a written request, signed by the patient or patient's legal representative, to the Privacy Officer at Smyrna Eye Group, P.C. I am aware that my revocation is not effective to the extent that the person(s) I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- ★ I understand that I do not have to sign this Authorization and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.
- ★ I understand that if the person(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.
- ★ I understand that a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing to anyone other another health care provider.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name Patient or Patient's Representative Relationship to Patient

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