Acuity Eye Group

Our Vision is Your Vision™

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. Requestor *Who is requesting the patient records?*	☐**Patient** *or* ☐**Patient's Representative**
2. Patient Information *Who is this information about?*	**Patient Name:**
	Date of Birth:
	Address:
	City: State: Zip Code:
	Phone number:
	Email:
3. Authorized Recipient *Who will be receiving this information?*	☐ **Patient** *(skip to section 4)* ☐ **Provider** ☐ **Other**
	Name:
	Address:
	City: State: Zip Code:
	Phone number: Fax:
4.Types of Records and Method of Delivery *Which records and how do you want to receive these records?*	**Method of Delivery:** ☐ **In Office** ☐ **Mail** ☐ **Email** ☐ **Fax**
	☐ **All my records** *or* ☐ **My records with the date range: ___/___/____ -- ___/___/_____**
5. Signature *Patient Sign Here*	I authorize Acuity Eye Group to disclose my Protected Health Information to the authorized recipient listed on this form in accordance with my rights outlined in this document: **Signature: _____ Date: ___/___/_____**

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6. Patient Rights *By signing this form, patient understands their individual rights about their protected health information*	I, the patient, or patient's representative, have the legal right to inspect, copy and request delivery as specified of this protected health information within the next 15 days in accordance with Section 123110 of the Health & Safety Code and 45 CFR 164.528. I accept the responsibility of **any fees associated with this request (maximum twenty-five cents ($0.25) per page for paper copies)** I have carefully read and understood this authorization. I consent to the release of the specified medical information by my physicians and their associates or representatives from any liabilities arising from release of the specified information made in good faith in accordance with this consent. I also understand that any information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. This authorization will expire on the later of one year from (1) the date below or (2) the date upon which my medical case has been closed and Acuity Eye Group has received full and final payment for services. I can ask for a copy of the protected health information that will be disclosed. A processing and/or copying charge may apply as permitted by law. My treatment may not be conditioned on my signing of this authorization. I may revoke this authorization at any time, but I must do so in writing to the clinic where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. Revocation of this authorization may carry consequences related to my employment or prospective employment. I have a right to not sign this authorization or to limit the information I authorize to be disclosed. I understand that my health information may not be protected from further disclosure by some entities receiving my information under this authorization, and that Acuity Eye Group has no control over subsequent disclosures by other entities. AEG is required to obtain reasonable verification of identity prior to permitting inspection or copying of patient records. Copies of legal documentation supporting legal guardian or personal representative relationship of the patient must accompany this release form. This form and supporting documentation must be completed in its entirety to be considered valid.
7. Patient Representative *Fill out only if records are requested **on behalf of patient** by personal representative*	**Name of Guardian/Representative:**
	Relationship to Patient:
	Address
	City, State Zip Code
	Phone number
	Email

Note: Please anticipate 15 days for processing of this request.
Please email or fax the completed form to medicalrecords@acuityeyegroup.com or fax to (626) 796-7657.