Acuity Eye Group®
Our Vision is Your Vision®

Authorization for Release of Protected Health Information

1 I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION AS FOLLOWS:

- ❍ All my records including all general health records, medical histories, examination and treatment notes, radiology and laboratory test results, consultation and referral notes, etc.
- ❍ My records related to treatment for (specific illness, injury or evaluation): _____
- ❍ Describe other records: _____

ADDITIONAL RELEASE – I further authorize the release of the following:

a. ❍ HIV / AIDS Related Information b. ❍ Inpatient Mental Health Records c. ❍ STD Information
d. ❍ Drug / Alcohol Treatment e. ❍ Psychotherapy Notes f. ❍ Other: _____

2 FROM: ❍ Acuity Eye Group

❍ Other Physician / Facility (provide name and address)

_____

3 TO: ❍ Myself ❍ Acuity Eye Group

❍ Employer or Prospective Employer (provide name and address)

_____

❍ Other Individual, Physician or Entity (provide name and address)

_____

4 FOR THE PURPOSE OF: ❍ At Patient Request ❍ Other Reason: _____

MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION

- 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. Contact your employer for details.
- 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.

SIGNATURE

Patient Signature _____ Date ____/____/____

Patient Name _____ Date of Birth ____/____/____