AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Requesting Medical Records From:

_____

_____

_____

Where to Send/Release Information:

Children's Eye Care
11013 Hefner Pointe Dr.
Oklahoma City, OK 73120

Patient Identification

Printed Name: _____ Date of Birth: _____Telephone: _____

Address: _____

Information to be Released – Covering the Periods of Health Care

From (date) _____to (date) _____

Please check type of information to be released:

__◯__Complete Record __◯__Clinic records __◯__Operative Notes __◯__Spectacle Correction __◯__Photographs
__◯__Diagnostic Reports __◯__Other (specify) _____

Purpose of Request

__◯__Further medical care
__◯__Other (specify)_____

Drug and /or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Record Release

I understand if my medical or billing record contains information in reference to drug/and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Circle One: ◯ Yes ◯ No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
Circle One: ◯ Yes ◯ No

The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or durg abuse patient.

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer, Jeanne Blasi, R.N., at Children's Eye Care, 11013 Hefner Pointe Dr., Oklahoma City, OK 73120. Unless revoked, this **authorization will be void 1 year from date of signature, unless otherwise specified.** Alternate date if not 1 year _____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signature of Patient or Personal Representative Who May Request Re-disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Children's Eye Care to use and disclose the protected health information specified above.

Signature: _____Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ◯ **Photo ID** ◯ **Matching Signature** ◯ **Other, specify** _____

Verified by: _____