PHI Disclosure Authorization/Medical Record Release

Cleveland Eye Clinic

Name of patient: ______________________ ______________ __________

Last Name First Name Middle Name

DOB: ____/____/______

Phone: ______________________

Address: ____

Request for release of PHI FROM Cleveland Eye Clinic:

I authorize Cleveland Eye Clinic to release my medical records to:

Name of Entity Information is **to be sent to**: fax: ______________________

______________ ______________________

Name Address

______________ ______________________

Name Address

Request for release of PHI TO Cleveland Eye Clinic:

Name of Entity information is being **requested from**:

____

Please send to:

Cleveland Eye Clinic, ______________________ (Office) Phone: ______________

______________________________ ______________

Address Fax

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing to ______________________ ______________. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that this authorization is effective 12 months from signature date unless a different expiration date is provided ___/____/______(specify new date)

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

____

Name of patient or Personal Representative (Type/Print)

______________________________ ______________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority

Identify verified with: _____ Driver's license or ______S.S.# or ______Date of birth

Staff who provided records: (printed name): ______________________

Physician signature: ______________________________