PHI Disclosure Authorization/Medical Record Release Cleveland Eye Clinic

Phone:	Name or patient:	Last Nar	me	First Name	Middle Name	
Address: Request for release of PHI FROM Cleveland Eye Clinic:						
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	Phone:		_			
I authorize Cleveland Eye Clinic to release my medical records to: Name	Address:					
Name	그 경기에 있는 경기를 받는데 살아 있다면 그렇게 되었다.	[12]				
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 understand that I have the right to terminate or revoke this authorization at any time. To do so, my request moverage in the revocation is not effective if my authorization was obtained as a condition of obtaining insurar overage. understand that this authorization is effective 12 months from signature date unless a different expiration data revocated that information that is disclosed under this authorization may be disclosed by the recipient, as su he 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 anyment, or enrollment or eligibility for benefits. Itame of patient or Personal Representative (Type/Print) Indicate the privacy of this information may not be protected under the protected as a condition to receive treatment anyment, or enrollment or eligibility for benefits. Indicate the privacy of the protected under the protected						
Request for release of PHI TO Cleveland Eye Clinic: Name of Entity information is being requested from: Please send to: Cleveland Eye Clinic,	Name of Entity informa	tion is to be sent to: Tax:				
Request for release of PHI TO Cleveland Eye Clinic: Name of Entity information is being requested from: Please send to: Cleveland Eye Clinic,	Name		Address			
Name of Entity information is being requested from: Please send to: Cleveland Eye Clinic,	Name		Address			
Please send to: Cleveland Eye Clinic,	Request for release of P	HI <u>TO</u> Cleveland Eye Clinic	:			
Address Fax I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request more orded to your office in writing to understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurar coverage. Understand that this authorization is effective 12 months from signature date unless a different expiration date or	Name of Entity informa	tion is being requested from	1:			
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