AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, (Print Name)_____(Date of Birth:_____), authorize OPHTHALMIC ASSOCIATES to disclose a copy of the health information identified below to:

(Print Physician / Office name, fax and/or address): _____
_____

for the following purpose(s):_____
_____

Describe purpose [e.g., for treatment; consultation; workers' compensation claim] or state "at request of patient".

By initialing the lines below, I specifically authorize the disclosure of the following health information and/or records, if such information and/or records exist to the above-named recipient:

____ All Medical Information (chart notes, operative reports and diagnostic results only)
____ Please send the entire record (all information including any information scanned in the chart, registration documents, and billing statements).
OR select only specific records from the following list:

____ All hospital records (including nursing records & progress notes)	____ Physician office chart notes
____ Transcribed hospital reports	____ Diagnostic imaging reports
____ Medical records for continuity of care	____ Laboratory reports
____ Most recent five-year history	____ Pathology reports
____ Emergency and urgent care records	____ Billing statement
	____ Other (specify) _____

_____

The following items, if applicable, must be initialed below to be included with the disclosure:

____ HIV / AIDS related health information and/or records
____ Mental health information and/or records
____ Genetic testing information and/or records
____ Drug/alcohol diagnosis, treatment and/or referral information

For these items, federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information. (Description if applicable) _____
_____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to

Ophthalmic Associates' HIPAA Privacy Officer at the address set forth above. Unless revoked earlier, this authorization will expire 365 days from the date of signing or on _____20_____.

I understand that I may refuse to sign this Authorization and this will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and may no longer be protected by such regulations.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative	Relationship to Patient

PLEASE COMPLETE FORM AND FAX BACK TO (907)264-2684

This form will be retained with the patient's medical records and a copy provided to the patient or the patient's legal representative.

For Office Use Only

Signature of Employee and Date Records Released:

_____	_____
Name of Employee	Date Records Released