OPHTHALMIC ASSOCIATES, a Professional Corporation
542 West Second Avenue, Anchorage, AK 99501

AUTHORIZATION TO RECIEVE HEALTH INFORMATION

I, (Print Name)______________________________(Date of Birth:______________), authorize (Print Physician / Office name, fax and/or address): ___________________________
____
____
to disclose a copy of the health information identified below to: OPHTHALMIC ASSOCIATES at address above or fax: (907)264-2684 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)
____ Transcribed hospital reports
____ Medical records for continuity of care
____ Most recent five-year history
____ Emergency and urgent care records
____ Physician office chart notes
____ Diagnostic imaging reports
____ Laboratory reports
____ Pathology reports
____ 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) ____
____

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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

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