EYE ASSOCIATES
OF COLORADO SPRINGS

AUTHORIZATION TO RECEIVE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City/State/Zip

_____
Phone Number / Fax Number

Release My Information To:

_____
Name of Person/Organization Receiving Information

_____
Address City/State/Zip

_____
Phone Number / Fax Number

INFORMATION TO BE RELEASED (Please Note: We have up to 30 days to release the records)

_____ Complete Medical Record

_____ Medical Records for Specific Dates of Service (please list) from _____ to _____

_____ Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA)*. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____ X _____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ By: _____ Via: _____