ELKHART OPHTHALMOLOGY

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Clinic or Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

Elkhart Ophthalmology
Name of Person/Organization Receiving Information

1628 W. Beardsley Ave. Elkhart, IN 46514
Address City / State / Zip

574-391-1020 // 574-391-1021
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

X Complete Medical Record
_____ Medical Records for Specific Dates of Service (please list) from _____ to _____
X Other (please list): Eye Exams, Visual fields, OCT's, Flow sheets, IOL calculations, topography, _____

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 above. 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 (HIPPA)*. 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)