Eye Care Northwest

Authorization for Release of Protected Health Information

1. PATIENT INFORMATION:

Last Name: _____ First Name: _____ Date of birth: _____/_____/_____

Email Address: _____ Home Phone:_____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I AUTHORIZE THE RELEASE OF PROTECTED HEALTH INOFRMATION AND MEDICAL RECORDS UNDER THE FOLLOWING TERMS AND CONDITON:

2. RELEASE RECORDS TO:

Self: ☐ Doctor: ☐ Other: ☐ (Eye Care Northwest, follow-up)

☐ Mail records

☐ Pick-up

☐ Fax records

☐ Expedite Date needed:_____

Name/Organization: _____

Street address: _____

City/ State/ Zip Code: _____

Phone: _____ Fax: _____

*A fee may be associated with your request for release of medical records. Please allow up to 7-10 business days for the request to be processed.

3. INFORMATION TO BE RELEASED:

Please be aware that records you have authorized for release may include information relating to discussion, testing, or treatment of HIV or AIDS. If you do not want such information to be included in the release, please check the boxes below:

☐ All records past to present

☐ Exclude information regarding HIV/AIDS

☐ Exclude information regarding substance abuse

Other information: special instructions:_____

4. SIGNATURE OF PATIENT (OR REPRESENTATIVE BY LAW):

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. To ensure appropriate continuity and follow up of your care at Eye Care Northwest, we ask that you check the box in section 2 above so that we can obtain your medical records from outside facilities as needed.

If you want to revoke your authorization, send us a written note telling us that your authorization is revoked to Omni Eye Services 485 Route 1 South, Building A, Iselin, NJ 08830.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

A facsimile or photocopy of the authorization shall authorize release of the records. This authorization shall be in force and effect until the records have been released:

Patient signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

OMNI EYE SERVICES USE ONLY:

☐ Reviewed by: _____ Date: _____

☐ Fee Paid: _____ Date: _____