

THE EYE CLINIC OF MONROE, AMC
AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. I, _____, hereby authorize _____
to disclose the following protected health information to:

2. The specific information subject to this authorization is:

- | | |
|--|--|
| <input type="checkbox"/> Necessary Medical Records Determined by the Physician | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consent Forms |
| <input type="checkbox"/> Diagnostic Testing | <input type="checkbox"/> Examination Forms |
| <input type="checkbox"/> Health History Form | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Lab/Special Reports | <input type="checkbox"/> Other |
| <input type="checkbox"/> Photographs | <input type="checkbox"/> Optical Information |

3. This protected health information is being used or disclosed for the following purposes:

4. This authorization shall be in force and effect until _____, at which time this authorization to disclose this protected health care information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to this Health Care Provider. I understand that a revocation is not effective:

- a. to the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or
- b. if the authorization is obtained as a condition of obtaining insurance coverage, if some other law or the policy itself provides the insurer with the right to contest a claim under the policy.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. I understand that this Health Care Provider may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide this authorization for the requested use or disclosure.

8. I understand that I have the right to:

- a. Inspect or copy the protected health information to be used or disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights, and
- b. Refuse to sign this authorization.

Signature of Patient or Representative

Print Name of Patient or Representative

Date

Date of Birth

Social Security Number