

GAINESVILLE EYE ASSOCIATES
Authorization for Use/Release of Health Information

By signing this form, I authorize Gainesville Eye Associates to use, release or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be Sent

Address of Person/Organization to Whom Information Should Be Sent

Patient Name _____

Please send this information on or about (information will not be resent without another authorization):

_____/_____/_____

This authorization expires upon fulfillment of request unless special circumstances noted below **

Mo
Day
Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ____/____/____ to ____/____/____

___ Copies of the information described below for period ____/____/____ to ____/____/____

___ History & Physical Examination ___ Lab, X-ray, etc. Reports ___ Reports from Other Physicians

___ Other (Please Specify)

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during dates above –

** Please describe any special requirements such as Faxing, certified mail, extended expiration date, and the like –

I understand that there may be information in these records that I would not want released.

I have been provided a copy of Gainesville Eye Associates *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Gainesville Eye Associates Privacy Officer or other appropriate office personnel.

I understand that Gainesville Eye Associates assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Gainesville Eye Associates from all legal liability that may arise from this authorization.

Patient's Signature _____ **Date** _____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the patient is: _____. Signed _____

The patient or their representative may revoke this authorization by notifying in writing Gainesville Eye Associates designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.