

AUTHORIZATION TO DISCLOSE PERSONAL MEDICAL INFORMATION

Effective _____ [date], I, _____ [Patient's name], hereby authorize the use or disclosure of my individually identifiable health information as described below.

1. I authorize the following organizations or individuals to use or disclose my health information: [check one]

- Gerald Geist _____, O.D.
- _____, M.D. [insert name]
- Other: [describe] _____

2. I authorize the following organizations or individuals to receive my health information:

- _____, O.D. [insert name]
- _____, M.D. [insert name]
- Other: [describe] _____

3. The information that may be used or disclosed: [specify]

4. The information will be used or disclosed for the following purposes [**all** purposes must be listed and described]:

Purpose 1

Purpose 2

[check if applicable] I have initiated this authorization and do not wish to provide a statement of the purpose. The use or disclosure is at my request.

5. I understand that this authorization is voluntary, and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or to be eligible for benefits.

6. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

[see next page]

7. I understand that I may revoke this authorization at any time by written notice to the person or organization providing the information. The revocation will not be valid, however, if:

- (a) the entity to which I am providing my authorization has taken action in reliance on this authorization; or
- (b) this authorization is obtained as a condition for obtaining insurance coverage, and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. This authorization expires on [upon] _____ [insert applicable date or event].

Signature of Patient

-or-

Signature of Personal Representative
of Patient

Date Signed

Relationship of Personal Representative
to Patient

[TO BE COMPLETED BY EMPLOYEE]
(check one)

- I know the individual making this request.
- I hereby verify the identity of the individual requesting protected health information and the authority of the individual to have access to the protected health information.

Signature of Employee

For Use Only by Practice:

Date Received: (MO/DY/YR) ____/____/____

Fee Charged for fulfilling this Request (if applicable): \$ _____

Name or Initials of Retail Associate processing this Request: _____

TO BE PLACED IN FILE OF PATIENT