# Associated Eye Care

**Limited Patient Authorization for Disclosure of Protected Health Information**

Please print all information. Form must be renewed every two years.

**Patient Name:** ___________________________________________________________________

**SSN: (last four digits):** ___________________ **Date of Birth:** ______________________

**Entity Requested to Release Information:** Associated Eye Care, Inc.

**Purpose of request (who will be authorized to receive information)** – I attest the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

**Who will be authorized to receive information?** (list the individual/entity who is to receive you PHI, eg. spouse, child, friend):

1.) Individual/Entity Name: ___________________________________________________________

Address: ______________________________________________________________________

Phone #: _____________________________________________________________________

2.) Individual/Entity Name: ___________________________________________________________

Address: ______________________________________________________________________

Phone #: _____________________________________________________________________

**Description of information to be disclosed** – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

□ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- □ office notes
- □ nursing home, home health, hospice, and other physician records
- □ lab results, pathology reports
- □ record of HIV and communicable disease testing
- □ X-rays
- □ record of mental health or substance abuse treatment
- □ financial history report (previous 3 years only)
- □ Only send the following: ________________________________________________________

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

□ Patient Request □ Other: (please specify) _____________________________________________

- This authorization will expire after two years from your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. Please list the expiration date if earlier than two years from the date below: ______________________
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- This practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative signature _____________________________________ Date _______________