



Athena Eye Institute
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AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____
 Street Address _____
 City _____ State _____ Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

Name of Person/Organization Releasing Information:

Organization Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone Number _____ Fax Number _____

To Release my Information To:

Name of Person/Organization Receiving Information:

Organization Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone Number _____ Fax Number _____

INFORMATION TO BE RELEASED:

- Complete Medical Record
- Medical Records for Specific Dates of Service (please list) from _____ to _____
- Laboratory Testing and Results
- Radiology Testing and Results
- Other: _____

This authorization will remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Printed Name of Patient/Representative _____

Signature of Patient/Representative _____ DATE _____

Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ By: _____ Via: _____