Eye Medical Center of Fresno

at the California Eye Institute
1360 E. Herndon Avenue, Suite 301 & 210
Fresno, California 93720

1122 'S' Street
Fresno, California 93721

Authorization To Disclose Protected Health Information

Request To:_____

Address: _____

_____

Date:_____ Date of Birth:_____

Patient Name:_____
Last First Middle

Last Date of Service:_____ SSN:_____

Telephone Number:_____ Alternate Number:_____

This information may be given to and used by the following individual or organization:_____

_____

Information to be used for the purpose of: ☐ Requested by patient ☐ Other:_____

I hereby request and authorize you to release information to:

Name:_____

Address:_____

METHOD OF RELEASE

☐ Picked up by patient ☐ Picked up by other than patient ☐ FAX Number ☐ Other

Date_____ Name_____ _____ _____

☐ Mailed to: _____
_____
_____

I authorize the use or disclosure of the above named individual's health information as described below.

Information to be released:

☐ Initial History & Physical
☐ All follow up visits
☐ Consultations: Specify date or doctors
_____
_____
_____
☐ Last Refraction Prescription

☐ Billing Information:
Dates_____to_____
☐ Medicare/Medical applications for services
☐ One or two page summaries of the chart
☐ Designated record set
☐ Consent forms
☐ "Prescription Pad" note

☐ List of all surgeries pertaining to the eye and orbits

OVER

☐ Laboratory Summary (to include these types and dates)

_____

_____

_____

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand the charge for copying records is .50 cents per sheet or a minimum $25.00 for complete records.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect the information to be used or disclosed, as provided in the federal privacy regulations.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

  _____

  If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting the Privacy Officer at (559) 449-5064.
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization.

  ☐ Will have no adverse impact on delivery of care or reimbursement of patient charges.

  ☐ Will have the following adverse impact:_____

Patient or Legal Representative Signature:_____Date:_____

Relationship to the patient:_____

Witness (office staff or signature of legal representative):_____Date:_____

Office Use Only: Copied by_____Date_____ID Type:_____Amount Received:_____

I revoke (cancel) this Authorization to Disclose Health Information previously signed on (date)_____

Cancellation Signature:_____Date:_____