Mountain Empire Eye Physicians, PLLC

Authorization for Release of Health Information

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party ;
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize the disclosure of my individually identifiable health information to the following person(s) or organization(s):

_____

Full Name of Person(s) or Organization(s)

_____

Full Address, Phone and Fax Number of Person(s) or Organization(s)

Type of Information to be Disclosed:

☐ I authorize disclosure of **all** my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or

☐ I authorize only the disclosure of the following information:

_____

Type of Information

Purpose of Disclosure:

☐ My health information is being disclosed for continuity of care to another healthcare provider;
☐ My health information is being disclosed at my request or at the request of my personal representative; or
☐ My health information is being disclosed for the following purpose:

_____

Explain Purpose (No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose.)

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative (if applicable) Relationship to Patient (if applicable)

**** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT ****