Authorization for Use or Disclosure of Protected Health Information

Patient Name:____**(PRINT)** **Date of Birth:**__________________

Address:____ **Telephone #**____________________

By signing this form, I authorize the following disclosure of protected health information:

[ ] From [ ] To	[ ] From [ ] To
Person or Facility ☐ **Check here if same as patient above**	**Ocala Eye, P. A.** **3130 SW 32nd Avenue** **Ocala, FL 34474** **(352) 622-5183** **(352) 629-5026 Fax**

Description of the information to be used or disclosed (*check all that apply*):

☐	Pertinent information (Exam visits and tests, no charge to patient)
☐	Entire patient chart (Charges apply)
☐	Specific documents:

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.
Expiration Date of Event: ______________________________

This authorization is for release of patient information including diagnosis, treatment, and/or examination related to mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible diseases. By signing this authorization, I am giving permission for the uses and disclosures of patient information described above. I understand that I have a right to inspect and to obtain a copy of any information disclosed. I hereby release and discharge Ocala Eye, P.A. and all persons acting under its permission and authority from any liability that may arise from the release of patient information as I have directed. I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Ocala Eye, P.A. cannot guarantee that the recipient(s) of the information will not re-disclose this information contrary to such prohibition.

You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical treatment.
I understand that this fee is within the limits allowable by Florida law.

I fully understand and accept the terms of this authorization.

______________________________________ ________________________
Patient's Signature Date

Relationship to Patient (if other than patient):_____________________________Date:______________

Authorization verified by____on________________________

Revised 10.11.13 KS

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