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
FAX		Ocala Eye, PA 4414 SW College Rd, Ste 1462 Ocala, Fl 34474 (352) 622-5183 Fax: (352) 629-5026	

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, PA 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, PA 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 allowed 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 _____