AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Telephone No. _____

City _____ State _____ Zip_____

I hereby authorize Texarkana Eye Associates to disclose the following Protected Health Information pertaining to the above-referenced patient to:

Name of Person or Entity_____ Telephone No. _____

Address _____ Fax No. _____

City _____ State _____ Zip_____

E-mail _____

DELIVERY METHOD: ☐ Mail ☐ Fax ☐ E-mail* ☐ Pick-up at _____ location

*PLEASE NOTE: Regulations require encrypted messaging systems for confidential communications. Since our e-mail/text communications are not encrypted, it is the policy of Texarkana Eye Associates not to use e-mail/text for sharing confidential information. Although it is unlikely, there is a possibility that information we include in an email/text could be intercepted and read by other parties besides the person to whom it is addressed. By signing below, you acknowledge these risks and would like us to send your personal health information via e-mail.

REASON FOR DISCLOSURE:

☐ Personal ☐ Treatment/Continuing Medical Care ☐ Disability ☐ Other _____

INFORMATION BEING REQUESTED:

☐ Glasses Prescription ☐ Last Exam

☐ Contact Lens Prescription ☐ Entire Medical Record ($15.00 fee)

☐ Other (please specify): _____

I understand this release may include disclosure of information relating to communicable diseases, acquired immunodeficiency syndrome (“AIDS”), human immunodeficiency virus (“HIV”), behavioral and/or mental health care, alcohol and/or drug abuse, if any such records exist.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Texarkana Eye Associates. Unless otherwise revoked, this authorization will expire after (1) year and a new authorization will need to be submitted.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I you any questions about the disclosure of your health information, you can contact our Privacy Officer at (903) 838-0783.

_____ Date: _____

Signature of Patient

_____ Date: _____

Signature of Parent and/or Guarding (if minor)