HARMAN EYE CENTER
An AVP Company

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Birth Date:_____

_____
Full Address: Street/City/State/Zip

_____ _____ _____
Telephone Number Social Security Number **(last 4 digits only)** Medical Record Number

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Disclosed Information

Please specify the information to be released (the exact information and format must be specified, e.g., verbal discussion, written reports, photographs, etc. and the dates or range of dates of treatment requested, if applicable

_____

_____

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Information Provided To

_____
Name of Person/Institution and Full Address Telephone Number

_____
Full Address: Street/City/State/Zip Email address or fax number for records to be sent to

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Purpose of the Requested Information

This information is requested for the purpose of_____

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Authorization Expires

This authorization Expires (insert date, event, or condition)_____If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

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Authorization

I hereby authorize Harman Eye Center to disclose the health information described above.

I understand that I may revoke this authorization at any time by written request made to the Privacy Officer, except to the extent that action has been taken in reliance on this authorization. My refusal to sign this form will not affect my treatment, except when I have requested a service by Harman Eye Center and the purpose of the service is to provide health information to a third party at my request. It is possible that information disclosed under this authorization might be disclosed by the recipient and no longer be protected. This form has been fully explained and I certify that I understand its contents.

Patient Signature_____Date_____

Signature of Person Authorized in Lieu of Patient_____

Relationship to Patient_____

Witnessed by_____Date_____

Records of deceased patients: If the requestor is not the executor of the decedents' estate then the requestor certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains.