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Protected Health Information Release Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize Catalina Eyecare, P.C. to use/obtain and/or disclose the protected health information described below to/from

____
[Name of Individual/Office/Location]

____
[Address of Recipient]

____________________ ____________________
[Telephone Number of Recipient] [Fax Number of Recipient]

____
[**Name and date of birth of patient requesting records]**

2. Release information covering the period of health care from ☐ ____________ to ____________ **OR**
   - ☐ all past, present and future periods:
   - ☐ I hereby **authorize the release of my complete health record** (This will be limited to 1 year of information including Lab and X-ray reports unless otherwise stated, which could include records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
   - ☐ I hereby authorize the **release of ONLY the following portion of my health record**:

   ____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

7. **PATIENTS PLEASE NOTE: The charge for copying medical records will be $2.00 for the first page and .25 for each additional basic black and white copy. Color copies will be $1.00 each.**

____________________ ____________________
Signature of Patient or Personal Representative Date

____________________ ____________________
Print Name of Patient or Personal Representative Relationship to Patient