The Eger Eye Group, PC

HIPAA Compliant Authorization for Release of Patient Information

Pursuant to 45 CFR 164.508

** Record release FROM The Eger Eye Group, PC **

Section I – Patient Information

Name:		
Street Address:		Birth Date:
City:	State:	
Telephone:		Email:

I, or my authorized representative, hereby authorize The Eger Eye Group, PC and their respective employees to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

SECTION II –Authorized Designee (to whom the information will be sent)

Name:		Relationship:
Street Address:		
City:	State:	Zip:
Telephone:		Fax:
Email:		

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to present or past medical conditions, surgeries, past or current medications and allergies, performed ophthalmic testing, spectacle prescription, contact lens prescription, and diagnoses only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.
2. I have the right to revoke this authorization at any time by writing to The Eger Eye Group, PC I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary. My treatment, payment, at The Eger Eye Group, PC or eligibility benefits will not be conditioned upon my authorization of disclosure.
4. Information disclosed under this authorization might be re-disclosed by the recipient, and the re-disclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.**

Section III – Specific Information to be Released:

☐ Please release my Medical/Ophthalmic Record from (insert year)_____ ____to (insert year)_____.

☐ Please release my entire Ophthalmic Medical Record, including patient histories, results from visual testing systems, contact lens information and prescription, spectacle measurements and prescription, (excluding billing records, insurance records sent to The Eger Eye Group, PC by health care providers).

Reason for release of information:

☐ At the request of the individual

☐ Other:

This authorization will be in effect for **one year** from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: _____/_____/_____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

Name:	Relationship:	
Street Address:	Telephone:	
City:	State:	Zip:

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

Signature of Member or Authorized Representative _____ Date: _____

Signature of Witness _____

Coraopolis Office

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