Arleo Eye Associates

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____DOB:_____

Please check any of the following choices, as applicable.

I authorize my protected health information to be released :

TO THE FOLLOWING:

Dr. / Office Name:_____

Address:_____

City:_____St:_____Zip:_____

Phone:_____Fax:_____

FROM THE ABOVE, TO ARLEO EYE ASSOCIATES

TO MYSELF

The type and amount of information to be used or disclosed is as follows:(include dates as necessary)

____All Records OR Specify:_____

Dates: _____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

The information will be used for:

____Continuity of Care; or Other:_____

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 the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of the signature below on this form. 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 to assure treatment. I understand that I may inspect or copy this 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 have questions about disclosure or my health information, I can contact the privacy officer for Arleo Eye Associates.

<u>According to Sections 17 and 18 of Public Health Law (PHL), Laws of 1991, Chapter 165, Sections 48 and 49;</u>
Arleo Eye Associates charges a fee of $0.50 per page of black and white copy and $1.00 per page of color copy.

_____ _____

Signature of patient or legal representative Signature of witness

Date:_____ Date:_____

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