DANBURY EYE PHYSICIANS & SURGEONS, P.C.
69 SAND PIT ROAD, DANBURY, CT 06810
PHONE: (203) 791-2020 – FAX: (203) 778-6238

RECORDS RELEASE AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. One occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

PATIENT'S NAME: ____________________ **DATE OF BIRTH:** __________ **PHONE #:** ____________________

FROM: ______________________________ **RELEASE TO:** ______________________________

Name | Name

______________________________ | ______________________________

Address | **Address**

______________________________ | ______________________________

______________________________ | ______________________________

FAX: ______________________________ | FAX: ______________________________

PHONE: ______________________________ | PHONE: ______________________________

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

_________ALL MEDICAL RECORDS INCLUDING BLOOD AND TEST RESULTS

_________ALL MEDICAL RECORDS INCLUDING BLOOD AND TEST RESULTS FROM ____________ TO ____________
DATE DATE

_________SPECIFIC INFORMATION TO BE RELEASED AS FOLLOWS: ______________________________

____

____

REASON FOR RELEASE: ____

IF RECORDS ARE BEING PICKED UP IN PERSON OTHER THAN BY YOURSELF, PLEASE STATE WHO YOU ARE GIVING PERMISSION TO DO SO: ____
NAME & RELATIONSHIP

PHOTO ID IS REQUIRED TO PICK UP RECORDS

THE ABOVE MENTIONED PROTECTED HEALTH IMFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE PARTY RECEIVING THE INFORMATION AND MAY NO LONGER BE PROTECTED BY THE PRIVACY RULES.

BY SIGNING THIS FORM, YOU AUTHORIZE DANBURY EYE PHYSICIANS & SURGEONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU FOR THE REASONS MENTIONED ABOVE. **IF APPLICABLE, THIS MAY INCLUDE INFORMATION ABOUT HIV, AIDS, SUBSTANCE ABUSE, ALCOHOL ABUSE, DRUG ABUSE, MENTAL HEALTH, SEXUALLY TRANSMITTED DISEASES, OR ANY SENSITIVE INFORMATION, ETC.** YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR AUTHORIZATION. SUBMIT YOUR REVOCATION TO THE PRIVACY OFFICER OF THE PRACTICE.

THIS AUTHORIZATION IS SIGNED BY: ______________________________ ______________
PATIENT NAME OR REPRESENTATIVE DATE

______________________________ ______________
WITNESS DATE

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM DATE OF SIGNATURE UNLESS SPECIFIED (Revised 2/08)