CONNECTICUT EYE CONSULTANTS, P.C.

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DANBURY FAX: 203-778-6238

Authorization for Use or Disclosure of Protected Health Information

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 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. 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 VALID FOR ONE YEAR FROM DATE OF SIGNATURE UNLESS SPECIFIED

I UNDERSTAND THAT THIS HEALTH INFORMATION MAY INCLUDE SENSITIVE INFORMATION WHICH MAY INCLUDE INFORMATION ABOUT HIV, AIDS, SUBSTANCE ABUSE, ALCOHOL ABUSE, DRUG ABUSE, MENTAL HEALTH, SEXUALLY TRANSMITTED DISEASES, OR ANY OTHER SENSITIVE INFORMATION.

If you have sensitive medical information you do not want disclosed, indicate which you DO NOT want released with your initials:

_____Substance Abuse Treatment Information **_____HIV related information, including AIDS related testing**

_____ Behavioral/Psychiatric/Mental health Services **_____Sexually transmitted diseases**

THIS AUTHORIZATION IS SIGNED BY: _____ _____
PATIENT NAME OR REPRESENTATIVE DATE

_____ _____
RELATIONSHIP TO PATIENT DATE

Revised 04/19