Prime Eye Care Specialists, Inc.
www.PrimeEyeCareSpecialists.com

Authorization to Disclose Health Information
(Request to Receive Records)

Patient Name: _____

Date of Birth: _____ SSN: _____

I hereby authorize the below named party to release and disclose of all my identifiable health information, which might affect the ongoing treatment of my eye disease to Prime Eye Care Specialists.

Name: _____

Address: _____

City, State, Zip: _____

I understand that this authorization is at my request, and I have the right to revoke this authorization in writing at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study), and that I may have the right to refuse to sign this authorization.

I have a right to receive a copy of this authorization.

SIGNATURE OF PATIENT (GUARDIAN OR AUTHORIZED REPRESENTATIVE IF PATIENT IS A MINOR)	
SIGNATURE	DATE
PRINTED NAME	TIME

7345 Medical Center Drive, Suite 320, West Hills, CA 91307 • Phone (818) 953-0093 • Fax (877) 883-9992
info@primeeyecarespecialists.com