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

Authorization to Disclose Health Information
(Request to Release Records)

Patient Name: _____

Date of Birth: _____ SSN: _____

I, hereby authorize Prime Eye Care Specialists to release and disclose of all my identifiable health information to the party below.

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

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