EMPIRE EYE PHYSICIANS

Authorization for Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Telephone: _____

PLEASE SEND MEDICAL RECORDS TO:

Recipient Name: _____

Recipient Address: _____

Recipient City: _____ State: _____ Zip: _____

Recipient Phone Number: _____ Recipient Fax Number: _____

Recipient Email Address: _____

FROM CLINIC/HOSPITAL:

Clinic/Hospital Name: _____

Clinic/Hospital Phone Number: _____ Clinic/Hospital Fax Number: _____

PURPOSE FOR DISCLOSURE:

☐ Referring Physician	☐ Patient Request	☐ Other: _____

RECORDS TO BE RELEASED:

☐ All Medical Records	☐ Operative Report	☐ Other: _____

DATES OF SERVICE:

☐ Please provide a complete copy of my file for all dates of service.
☐ Please provide a complete copy of my file for service from _____ through _____.

By signing the form below you understand that your records are confidential and cannot be disclosed without written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

DATE: _____ SIGNATURE: _____
Patient or Legally Authorized Representative

PRINTED NAME: _____
Printed Name of Patient or Legally Authorized Representative

****Please allow several days for processing****