

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301-4-307.

I hereby authorize *Washington Eye Physicians & Surgeons* to release the protected health information of:

PATIENT: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

The information is to be released to:

NAME: _____

ADDRESS: _____

PHONE #: _____

The information I wish to have released is (include dates of service):

- | | |
|--|---|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Imaging reports |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reports of operations | |

If *Washington Eye Physicians & Surgeons* is in possession of records from another provider, I do ____ I do not ____ wish to have those records released under this authorization.

The purpose for such disclosure is:

- | | |
|---|--|
| <input type="checkbox"/> At my request (only patient may check) | <input type="checkbox"/> Payment/Insurance |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Employment |

This authorization will expire one year from the date it is signed unless a shorter time is indicated here:

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that the action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify *Washington Eye Physicians & Surgeons* in writing.
- I understand that once information covered by this authorization has been disclosed redisclosure of information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

Patient or Personal Representative's Signature

Date

If signature is other than patient, explain your authority to act for the patient:

Medical Records Copying Fees:

Less than 10 pages: No charge
10 or more pages: \$.76/page plus postage