AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

Northwest Eye Physicians, PC
Name of Person/Organization Receiving Information

26850 Providence Parkway, Suite 440 ***Novi, MI 48374***
Address City / State / Zip

(248) 380-8280 (248) 380-8411
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record, including tests such as visual fields, OCT, etc. when applicable
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ **X**_____
Printed Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ **X**_____
Description of Personal Representative's Authority (attach necessary documentation) **Date**

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Date Sent: _____ By: _____ Via: _____