AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____ D.O.B:___________________

Address:__________________________________City/State/Zip:_______________________________

Telephone number:_____________________________________

1. **I request and authorize Lighthouse Low Vision Clinic to Release Information TO:**

Name of Provider____

Street Address____

City/State/Zip code____

2. **I AUTHORIZE THE FOLLOWING INFORMATION TO BE DISCLOSED: (PLEASE INITIAL ALL THAT APPLY)**

Dates of Service related to this referral_______________ to ___________________

__Office Visit notes

__Medical and Ocular Hx report

__Ocular Diagnostic Test results (VF, OCT, etc)

__Medical Insurance Information

__Other: ___________________

3. **For the Purpose of: (Please initial all that apply)**

__Continuation of care

__Disability/SSI Work Comp

__Self/Personal copy

__Other: ______________________

ADDITIONAL PATIENT INFORMATION:

I give my specific authorization for these records to be released. In return for releasing these records in response to my request, I release you and your staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time in writing, except that revocation will not affect any releases of records which have taken place prior to receipt of revocation. This authorization to release records expires 365 days from date signed. Further release of this information to other parties may not be done without further authorization from me.

____ ________________

Patient or legally authorized individual signature **Date**

Office use only:

____ ___________________________

Records Released by (employee) **Date Information was released**

______ Faxed _______ Mailed ______ Other _________________________