Ophthalmic Physicians Incorporated

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Information	
Name	Last 4 of SSN
Address	City, State & Zip
Date of Birth	Phone
Disclosed By	***Release To***
Ophthalmic Physicians Incorporated 8140 Norton Parkway, Suite 110 Mentor, OH 44060 Phone: (440) 255-1115 / Fax: (440) 255-1550	Name: _____ Address: _____ City, State & Zip: _____ Phone: _____ Fax: _____
Purpose and Expiration	
Purpose of Disclosure: _____ *(i.e. Personal, Legal, Employment, School, Clinical Trial, etc.)* This authorization shall expire on the following date or event: _____	

Information To Be Disclosed		
◯ Chart Notes	◯ Imaging	◯ Labs
◯ Operative Reports	◯ Spectacle/Contact Prescriptions	◯ Other (*please specify)*
Dates of Service From:	To:	

Delivery Method		
◯ Pick Up	◯ US Mail	◯ Fax

I understand that if I fail to specify an expiration date or event, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time. Any revocation will not apply to information that has already been released in response to this authorization. I realize that if the person or entity that receives this information is not a health care provider or health plan, my information may be redisclosed by such person or entity and will likely no longer be protected by privacy regulations. I also understand that I have the right to refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form. I further understand that I may request a copy of this signed authorization.

Patient/Legal Representative Signature: _____ **Date:** _____

Relationship (if not Patient): _____

If not patient, a copy of legal paperwork verifying the patient's personal representative must accompany the request (i.e. durable power of attorney) except a parent signing for a patient under the age of eighteen.