AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Name:	Phone #:
Date of Birth:	Social Security # (last 4 digits):

I authorize medical records to be released:

Medical Records Information From:		**Medical Records Information To:**
		Heaton Eye Associates
		3415 Golden Road
		Tyler, TX 75701
Phone #:		Phone #: 903.526.0444
Fax #:		Fax #: 903.526.2051

For the reason of: _____

Please release the following for Date of Service: _____

☐ Problem List / Exams	☐ X-Ray/Imaging Reports	
☐ Progress Notes	☐ Laboratory Results	
☐ History/Physical Exam	☐ Other Diagnostic Reports specify):	
☐ Medication List	☐ Visual Field Tests	
☐ List of Allergies	☐ Other (specify):	

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I under-stand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, **this authorization will expire in six months.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 3355 Earl Campbell Pkwy. Tyler, TX 75701 or call 800-762-5787 or 903-526-0444.

_____ _____

Signature of Patient / Legal Representative Date

_____ _____

Relationship to Patient / If Legal Representative Witness