

## Authorization to Release and Obtain Health Information

 Patient's Full Legal Name:
 \_\_\_\_\_\_Date of Birth:

Social Security Number: XXX-XX Phone Number:

COMPLETE the appropriate section below to SEND OR GET health information.

<b>PLEASE SEND HEALTH INFORMATION TO:</b> (Where do you want the information sent?)			PLEASE GET HEALTH INFORMATION FROM: (Who has the information you want released?)			
Name of Patient/Guardian/Provider/Clinic/Organization			Name of Provider/Clinic/Organization			
Street Address			Street Address			
City	State	Zip Code	City	State Zip	code	
Phone	Fax		Phone	Fax		
RECORDS to be:		mailed	Picked upFa		Faxed	

If sending information to guardian, please list relation to patient\_\_\_\_\_

I AUTHORIZE the following information to be disclosed (mark those that apply):

\_\_\_\_\_ Any and all records in the possession of Somerset Ophthalmology including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released).

\_\_\_\_\_ Records regarding treatment for the following condition or injury \_\_\_\_\_\_

\_\_\_\_\_ Records covering the period of time from \_\_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_.

**REASON** for disclosure of health information:

personal use	Legal	Insurance	Disability	Other:	ADDITIONAL

## PATIENT INFORMATION

I understand that I have the right to revoke this authorization in writing at any time by sending such notification to Privacy Officer, Somerset Ophthalmology, 2877 Crooks Rd., Ste. B., Troy, MI 48084. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. This authorization expires six months from the date of the signature. A copy of this authorization will be provided to me upon request.

Signature of Patient or Representative

Date