

NASHUA EYE ASSOCIATES
Patient's Authorization to Use and Disclose Health Information
(Release of Information)

Printed Name of Patient _____ D.O.B. _____
Daytime phone number _____

I authorize the use or disclosure of my protected health information (PHI) as describe below:

1. Description of PHI that may be used and/or disclosed:
 Entire Chart Office Notes Only
 Other. Please specify exactly what information you wish to have released. _____
Please specify a date or range of dates for the information you wish to have released. _____

2. Name of person(s) and/or organizations that may receive and use the information being *released*
TO: _____ **FROM:** _____

3. The purpose for which the information is to be used.
 Patient relocating Change of insurance coverage
 Patient seeking second opinion
 Other. Please specify the reason for the request

4. This authorization will expire on _____ or 90 days from the date of this request.

5. I understand I may revoke this authorization at any time by making my request in writing. I understand that there is the potential for re-disclosure by the recipient of the information. I understand that I am not required to sign this authorization as a condition of obtaining treatment or receiving services.

By signing below, I acknowledge that I have read and understand this authorization form.

Signature of Patient OR their Representative

Date

PRINT REPRESENTATIVE'S NAME

Relationship to Patient

A copy of the POA (power of attorney) must be provided to us when someone who has the POA represents the patient. A fee will be charged for copies of records which are not sent directly to another medical provider or medical facility.