ABILENE EYE INSTITUTE , 2120 ANTILLEY ROAD, ABILENE, TEXAS 79606
325-695-2020, 800-692-2020, 325 695-2326 (FAX)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

NAME:_____ **DATE OF BIRTH:** _____

ADDRESS: _____

SOCIAL SECURITY #: _____ **TELEPHONE:** _____

THIS INFORMATION IS TO BE RELEASED:
DOCTORS NAME:

FROM: _____

_____

_____
CITY STATE ZIP

DESTINATION OF MEDICAL RECORDS:
_____MAIL _____PICKUP

TO: _____

_____

_____
CITY STATE ZIP

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED

□ Complete Medical Record	□ History and Physical Exam	□ Consultations
□ Laboratory Test Results	□ Photographs, videotapes	□ Progress Notes
□ Diagnosis & treatment Codes	□ Radiology/ Imaging Reports	□ X-ray films/ images
□ Itemized Bill	□ Other (Specify)	

PURPOSE OF REQUEST – IF NEEDED FOR APPOINTMENT, PLEASE SPECIFY:

Date of Appointment: **Time:**

□ Continuing care	□ Consultation	□ Legal Purposes
□ Insurance	□ Personal Use	
□ Other: Please describe:		

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

Re-disclosure

I understand the information disclosed by the authorization maybe subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Privacy Officer of Abilene Eye Institute 2120 Antilley Rd, Abilene TX 79606. Unless revoked, this authorization will expire 180 days from date of signature.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. I authorize Abilene Eye Institute to use and disclose the protected health information specified above.

Signed: _____ Date: _____

If this authorization is signed by a personal or legal representative, please complete the following:

Personal/Legal Representative's Name: _____

Relationship to Patient: _____

Basis for Representation (POA, Guardianship, etc)_____
(PLEASE ATTACH COPY OF LEGAL DOCUMENT)