PALM VALLEY
EYE CARE & SURGEONS

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

PALM VALLEY EYE CARE AND SURGEONS
Name of Person/Organization Receiving Information

151 Sawgrass Corners Drive, Suite 208 Ponte Vedra Beach, FL 32082
Address City / State / Zip

904-712-3315 / 904-712-3316
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____ Complete Medical Record

_____ Medical Records for Specific Dates of Service (please list) from _____ to _____

X _____ Other (please list) Current and previously treated medical conditions, surgical history, allergies, and medication list

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____ X _____

Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ By: _____ Via: _____