The Eye Care Group
Excellence and Compassion in Eye Care

AUTHORIZATION TO DISCLOSE OR OBTAIN HEALTH INFORMATION

I, _____ authorize the disclosure of health information about the following:

☐ my health information (DOB _____/_____/_____)
☐ my minor child/children's health information: Child's name _____DOB _____/_____/_____
☐ the health information of the patient for whom I am the authorized representative:
Patient's name _____DOB _____/_____/_____

COMPLETE FOR THE EYE CARE GROUP TO DISCLOSE	COMPLETE FOR THE EYE CARE GROUP TO OBTAIN
I authorize The Eye Care Group to disclose health information about the above person to: Name: _____ Facility: _____ Street Address: _____ City, State, ZIP Code _____ Telephone: _____ Fax#: _____	I authorize _____ To disclose health information about the above person to: The Eye Care Group, P.C. 1201 West Main Street, Suite 100 Waterbury, CT 06708 Telephone: 203-597-9100 Fax#: 203-596-4758
Method of Disclosure: ☐ Mail ☐ Fax ☐ Pick-up	

I request that the information to be disclosed or obtained consist of the following: CHECK ALL THAT APPLY:
(A charge of up to $0.65 per page copied is generally allowable under Connecticut state law)

☐ Complete Medical Record (including records from other providers) ☐ Only Medical Records from The Eye Care Group Physicians

☐ Medical History, Evaluation Records ☐ X-Ray Imaging Reports ☐ Laboratory Reports ☐ Images
☐ Hospital Records, Including Reports ☐ Injections ☐ Prescription Data
☐ Consultation Documentation ☐ Surgical Reports ☐ Summary of Record
☐ Other (Specify):_____

The following types of information may be included if part of my medical record unless I specifically refuse authorization for its release by checking the appropriate box below:

☐ Genetic Testing ☐ HIV/AIDS
☐ Substance Abuse (alcoholism or drug abuse) ☐ Medical Treatment for Mental Health Conditions

The purpose of the disclosure is as follows (CHECK ALL THAT APPLY):

☐ At the request of the individual signing this authorization (no purpose need be specified)
☐ Additional Medical Care ☐ Change of Provider ☐ Insurance Eligibility/Benefits ☐ Legal Investigation or Action
☐ Relocation ☐ Other (Specify): _____

I understand that the disclosed information may be re-disclosed in accordance with law and may no longer be protected by the federal privacy standards. However, other state or federal laws may prohibit the disclosure of specially protected information, such as substance abuse treatment information, HIV/AIDS related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION: I understand that I am under no obligation to sign this form and that The Eye Care Group, P.C. may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying The Eye Care Group in writing of my revocation. To obtain information on how to revoke my Authorization, I am to contact The Eye Care Group's Privacy Official at 1201 West Main Street, Suite 100, Waterbury, CT 06708, Attention: Privacy Official. I am aware that my revocation will not be effective as to disclosures of the health information already made in reliance of this Authorization.

EXPIRATION DATE: This Authorization is valid for one (1) year unless I revoke it sooner in writing. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____
PATIENT'S OR REPRESENTATIVES'S SIGNATURE **PRINTED NAME**

_____ _____
REPRESENTATIVE'S RELATIONSHIP (IF APPLICABLE) **DATE**