Ophthalmology Consultants, P.A.

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Authorization to Release Protected Health Information

Patient Name: _____ DOB: _____
Parent/ Legal Guardian: _____ Phone: _____
Address: _____
_____

I hereby authorize Ophthalmology Consultants, PA to release my health information to the following designee:

Recipient Name: _____
Phone: _____ Fax: _____
Address: _____
_____

For the purpose of : (circle one):
Treatment Payment Healthcare Operations Other: _____

Type of information to be released is as follows:
☐ Entire Record ☐ Billing Records
☐ Operative Reports ☐ Other: _____
☐ Consultation Reports
Date(s) of service from _____ to _____

- This authorization shall be in effect until revoked by me in writing.
- I understand that I may revoke this authorization at any time by notifying Ophthalmology Consultants, PA in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.
- I understand authorization for the use or disclosure of the information identified is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

*There is a $25 fee when applicable
Please allow 15 days notice for releases.

_____ _____
Signature of Patient or Personal Representative Date
□Self □Parent/Guardian □Power of Attorney □Other

Identification verified by ☐ Drivers License ☐ Other picture ID (Name):_____ OCPA staff initials _____