EMPIRE
EYE & LASER CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ **Date of Birth**: _____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

I authorize Empire Eye and Laser Center (EELC) to discuss my PHI with the following individuals. This may include information about my appointments, diagnoses, and treatments.

Name:_____DOB:_____

Phone:_____Relationship:_____

Name:_____DOB:_____

Phone:_____Relationship:_____

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless otherwise specified. I may revoke this authorization at any time by notifying EELC in writing. My revocation will not affect actions taken by EELC prior to its receipt.

I understand that once the information is disclosed, it may be re-disclosed by the recipient; federal and/or state privacy laws may or may not protect the re-disclosure. I understand that authorizing the disclosure of information identified above is voluntary, and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

I have had the opportunity to read and to consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____	_____	_____
Patient/Authorized Signature	Printed Name (If not patient, indicate relationship)	Date