AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ **Date of Birth**: ____________________

Address: ____

I authorize and request Empire Eye and Laser Center (EELC) to

❏ **Obtain PHI from** ❏ **Disclose PHI to**

Name/Organization: ____

Address: ____

____

Fax: ____

❏ Pickup ❏ Mail Records ❏ Fax Records

If releasing information to EELC and affiliates, please send to

4105 Empire Drive
Bakersfield, CA 93309
Phone: 661-325-3937 / Fax: 661-283-3937

Information to be Disclosed:

Dates to disclose: From _______________ to _______________

❏ All Medical Records
❏ Specify:

Purpose of Disclosure:

❏ Continuation of care
❏ At the request of the individual
❏ Other:

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.

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. A fee may be charged for copying the protected health information.

____________________________ ____________________________________ __________________

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