Name:
Chart:
Date:

EYE CARE INSTITUTE
Authorization for Release of Protected Health Information

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization. Records not released directly to another health care provider may be subject to a minimum $15.00 medical records fee.

1. To be completed by the patient or the patient's authorized representative:

Patient's Name		Date of Birth
Street Address		Telephone Number
City	State	Zip Code

2. I hereby authorize: **EYE CARE INSTITUTE:**
3035 Cleveland Ave, Suite 100
Santa Rosa, CA 95403
Phone (707) 546-9800 Fax (707) 899-7980

☐ To release my confidential health information **to**:
☐ To obtain my confidential health information **from**:

Name		Telephone number
Organization		Fax number
Street Address		
City	State	Zip Code

3. In the following manner:

☐ Copies by mail ☐ Inspection
☐ Copies by fax ☐ Other: _____
☐ Copies to be picked-up

4. The health information being released may be used for the following purpose(s) only:

_____

_____

-CONTINUED-

5. My authorization is for the use and disclosure of the following records (please initial):

_____Any and all medical records

_____ Only specific records (please specify dates of service or types of records)

_____

_____ AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus) information, or other sexually transmitted disease

_____ Substance abuse and/or rehabilitation records

_____ Mental health records

_____ X-Rays

Information that is disclosed under this authorization may not lawfully be disclosed again by the person or organization to which it is sent unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. The privacy of this information may not be protected under federal privacy regulations.

This authorization shall be effective immediately and shall remain in effect until ____ or for one year from the date of signature. This authorization may be revoked in writing at any time. My written revocation will be effective upon receipt but will not be effective to the extent that EYE CARE INSTITUTE or others have acted in reliance upon this authorization. I understand that I may request a copy of this signed authorization.

Signature of Patient	Date
Signature of Parent or Personal Representative	Date
Name Parent or Personal Representative (please print)	Telephone
Description of Legal Authority to Act on Behalf of Patient	

Form revised 5/20/2024