Authorization to Release Medical Records

ANNAN
RETINA EYE CENTER

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** MM/DD/YYYY

Telephone: Home: _____**Work:** _____ **Cell:** _____

Address: _____ **City/State/Zip:** _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Please select one option from each column

Send records to ☐ or **Request records from** ☐	**Send records to** ☐ or **Request records from** ☐
If information is to be released by us, please complete this form and FAX or MAIL to: **Annan Retina Eye Center** 6550 Mapleridge St. Suite 125 Houston, TX, 77081 **FAX:** (346) 787 - 2267	**Name:**_____ **Address:**_____ **City/State/Zip:**_____ **Phone:** **FAX:**

INFORMATION TO DISCLOSE – Please select one	**REASON FOR DISCLOSURE** – Please select one	**DATES TO DISCLOSE** – Please select one
☐ Ophthalmological/Eye Examinations ☐ All medical records ☐ Specific information (please specify):	☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal	☐ All dates ☐ Last 2 years ☐ Other

PATIENT AUTHORIZATION

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)

_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Send Records to" I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that authorizing the disclosure of this health information is voluntary. I can't be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ **DATE** _____
Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____
(must attach documentation of such status)

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____
Signature of Minor Individual

Please allow 10 business days to process your request before calling: (346) 22ANNAN
All requests are processed in the order they are received.
There is a $25 clerical fee for the release of medical records.