GULF COAST EYE CENTER – 228-875-6658
Authorization for Disclosure of Health Information

RETURN COMPLETED FORM TO: Gulf Coast Eye Center, PO Box 916, Ocean Springs MS 39566

Patient Name: ______________________________ **Birthdate:** ____/____/____
Full Address: ______________________________
Phone #'s: ______________________________ **Last 4 digits of Social Security #:** __________

I hereby authorize Gulf Coast Eye Center to take the following action (check ONE):

☐ Provide a copy of **My Health Information** to me, **OR** ☐ Release **My Health Information** to the following:

Person or Organization's Name: ______________________________
Full Address: ______________________________
Phone #'s:

For this Authorization, **"My Health Information"** means (check one or more):

☐ Entire medical record ☐ ER reports ☐ Progress notes ☐ Discharge summary
☐ Operative reports ☐ History & physical ☐ Lab work/X-rays ☐ Billing records
☐ Other (specify): ______________________________

Dates of Service: ____/____/____ **to** ____/____/____

Sensitive Information: Information to be disclosed may include records related to alcohol and drug abuse treatment, behavioral and/or mental health care, sexually transmitted diseases including HIV/AIDS, and genetics. **If you do not wish to have any of these categories of information be disclosed, please specify:** ______________________________

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Purpose of Release: ☐ Medical care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other: __________
Requested Format (check one): ☐ Electronically on flash/thumb drive ☐ On paper
Delivery Method (check one): ☐ Pick up at office (through 9/28/18) ☐ Mail

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that signing this Authorization is voluntary. My treatment will not be conditioned upon my authorization of disclosure. I may revoke this Authorization at any time by mailing a written notice of revocation to Gulf Coast Eye Center, PO Box 916, Ocean Springs MS 39566. The revocation will be effective upon receipt by Gulf Coast Eye Center. Revocation will not apply to information that has already been disclosed in response to this Authorization. Unless revoked, this Authorization expires six months (180 days) from the date of signing unless I indicate an earlier date or event here: ______________________________. Once **My Health Information** is disclosed as requested, it may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it. If I requested an electronic copy of my information on portable media (e.g., flash or thumb drive), I understand that the information is not encrypted or password protected and that it is my responsibility to take precautions to protect it. By choosing to receive my information on such portable media, I am acknowledging and accepting these risks. Medical records requested by August 31, 2018 will be provided at no charge. Copies requested after that date are subject to reasonable fees for duplication and postage as allowable by law. I agree to pay this fee. I may inspect or copy the information to be used or disclosed under this Authorization. I also have the right to receive a copy of this signed Authorization.

I hereby release and agree to hold harmless Gulf Coast Eye Center, its employees, officers, and physicians, from any and all liability associated with the disclosure of protected health information to the extent indicated and authorized herein. **I, the undersigned, authorize Gulf Coast Eye Center to release My Health Information as indicated/described above. By signing, I acknowledge that I understand and agree to the terms on this form.**

______________________________ ______________________________ ____/____/____
Signature of Patient or *Personal Representative | Printed Name | Date Signed

* If Personal Representative, relation to patient: ______________________________ Phone #: ______________________________

Office Use Only:	**Date Recvd:** ____/____/____	**Date Records Provided:** ____/____/____ ☐ Flash drive ☐ Paper	☐ Pick up ☐ Mail