



World Class Eye Care. Hometown Service.™

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone #: _____

Information to be released – ALL information unless otherwise specified

Other, (specify): _____

Purpose of Request

_____ Treatment or Consultation _____ At the request of the Patient _____ Billing/Claims

Other, (specify): _____

I, the undersigned authorize and request Boozman-Hof Regional Eye Clinic, P.A. To:

OBTAIN FROM:

Or

RELEASE TO: - (circle one)

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to Drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment and/or other sensitive information.

Re-disclosure

I understand that once information is released to the above named entity, my information may be subject to re-disclosure. I can inspect or copy the protected health information to be used or disclosed.

Time Limit and Right to Revoke Authorization:

This form is valid for one year from signature/authorization signature date.

The Authorization for release of information form does not authorize re-disclosure of Medical Information beyond the limits of this consent. Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature: _____ Date: _____

Other Authorized Signature: _____ Relationship: _____