Phone: (860) 531-3852 Fax: (860) 468-4235

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Full Name: ________________________________ Date of Birth: _______________________

Patient Address: ____

City: ________________________ State: ______ Zip Code: _________ Phone: _______________

I authorize any member of the medical staff of Westchester Eye Care to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this authorization, except to the extent that the entity has already taken action in reliance on this authorization. The written revocation letter must be sent to Westchester Eye Care. I understand that once the PHI listed below is used or disclosed as set forth in this authorization, such information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I am under no obligation to sign this form and that Westchester Eye Care may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form.

Previous Office:____

The records should be sent to: **Westchester Eye Care, 715 Middletown Road Colchester, CT 06415**

INFORMATION TO RELEASE

I request that the information to be used or disclosed consist of the following **CHECK ALL THAT APPLY:**

- ❑ Complete Medical Records (Including records from prior providers)
- ❑ Last Exam
- ❑ Retinal Photos
- ❑ Glaucoma Tests
- ❑ Glasses Rx
- ❑ Contact Lens Rx

PURPOSE OF USE

- ❑ At the request of the individual
- ❑ Other: ____

I understand that state law prohibits the recipient from disclosing specially protected information, e.g., substance abuse treatment information, HIV/AIDS-related information, and mental health information, unless specifically authorized by me.

- ❑ Sensitive information regarding HIV/AIDS, or treatment for substance abuse (alcoholism or drug abuse) and/or mental health issues may be disclosed
- ❑ I do not authorize the release of sensitive information regarding HIV/AIDS, or treatment for substance abuse and/or mental health.

EXPIRATION DATE: This Authorization is valid for one year from the date signed unless otherwise specified here:

____

SIGNATURE: *If the patient is unable to sign, please indicate the authority of the person who is signing for the patient.*

____________	_________________________	_________________________	________________
Date	Signature of Patient/Representative	Print Name	Relationship to Patient