



**AUTHORIZATION FOR USE OR DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

**\*\*\*ENTIRE FORM MUST BE COMPLETED FOR RECORDS TO BE RELEASED\*\*\***

I authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of substance abuse, psychiatric/mental health information of HIV/AIDS information) of:

Printed Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Phone Number \_\_\_\_\_ Alt Number \_\_\_\_\_

**Person/Organization Authorized to Release Information**

**Person/Organization Authorized to Receive Information**

\_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
Phone \_\_\_\_\_

\_\_\_\_\_  
Phone \_\_\_\_\_

**I REQUEST THE FOLLOWING PROTECTED HEALTH INFORMATION**

- \_\_\_\_\_ Exam notes for last two visits
- \_\_\_\_\_ Most recent diagnostic test/lab results
- \_\_\_\_\_ Entire medical record generated by Midwest Retina, Inc.
- \_\_\_\_\_ Other (please be specific) \_\_\_\_\_

**PURPOSE OF REQUEST**

- |  |                         |                      |
|--|-------------------------|----------------------|
| _____ Continuity of Medical Care       | _____ Transfer of Care  | _____ Military       |
| _____ Self                             | _____ Insurance Billing | _____ Disability/SSI |
| _____ Legal Reasons                    |                         |                      |
| _____ Other (please be specific) _____ |                         |                      |

I understand:

- This authorization shall be in force and in effect for one year from the date signed.
- Under the Ohio Revised Code, a copying fee may be charged for providing a copy of the requested medical record.
- I have the right to revoke this authorization, in writing, at any time by sending such written notification to Administrator at Midwest Retina, Inc. A revocation is not effective to the extent that Midwest Retina, Inc. has taken action based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I further understand that if the person or entity receiving information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations
- Midwest Retina, Inc. will not condition my treatment, payment or healthcare options on whether I provide authorization for the requested use or disclosure.

This authorization and request is fully understood and made voluntarily on my part. I release the above-named facility of any legal liability that may arise from release of the information requested.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Guardian/Legal Representative \_\_\_\_\_ Signature \_\_\_\_\_