# Eyecare Plus

## Authorization For Use/Disclosure of Protected Health Information

**Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164**

Patient full name: _____ DOB:_____
Maiden/Other name:_____
Current address:(city, state, zip):_____
Patient Phone: (home)_____ (cell)_____

**I authorize:**

❏ Eyecare Plus, 301 Petrol Point, Peachtree City, GA, 30269, (V) 770.487.2020 (F) 770.487.2720

❏ _____
(Doctor/Office Name) (Address)
_____ _____
(Phone, needed to verify fax) (Fax)

**to use and disclose the protected health information described below to:**

❏ Eyecare Plus, 301 Petrol Point, Peachtree City, GA, 30269, (V) 770.487.2020 (F) 770.487.2720

❏ _____
(Doctor/Office Name) (Address)
_____ _____
(Phone, needed to verify fax) (Fax)

**Description of information to be released:**

- ❏ Entire Medical Record
- ❏ Most Recent Visit, Including Testing
- ❏ Dates _____ through _____
- ❏ _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that this authorization will expire: **upon completion of this disclosure/use.**

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**Patient/Guardian Signature:**_____ **Date:**_____

**Print Name:**_____