MORGANTON EYE PHYSICIANS, PA
Authorization for Use or Disclosure of Health Care Information

Name: _____ Phone: _____ Date of Birth _____

SSN: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I am requesting my records be released to Morganton Eye Physicians, PA from:** (Physician/Practice Name and Address)

_____

_____

By signing this form, I authorize the use and disclosure of my health information as described below:

___ All Clinical Medical Records from date _____ to date_____

___ Other Records – Please List (e.g. billing, angiograms, photographs): _____

_____

Please release the above information to the following Morganton Eye Physicians location attn: Medical Records Department:

Morganton Eye Physicians, PA
335 East Parker Road
Morganton NC 28655
FAX: 828-430-3465

Marion Eye Clinic
40 East Medical Court
Marion NC 28752
FAX: 828-652-7170

Cleveland Eye Clinic
1622 East Marion Street
Shelby NC 28150
FAX: 704-482-7707

Forest City Eye Clinic
640 Oak Street
Forest City NC 28043
FAX: 828-245-0551

Rutherford College Eye Clinic
PO Box 387
Rutherford College NC 28671
FAX: 828-874-4142

Circled address indicates location to send records.

☐ **I am authorizing Morganton Eye Physicians, PA to release my health information to:** (Physician/Practice Name and Address)

_____

_____

By signing this form, I authorize the use and disclosure of my health information as described below:

___ All Clinical Medical Records from date _____ to date_____

___ Other Records – Please List (e.g. billing, angiograms, photographs): _____

_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. Date or event when authorization expires: _____

- I understand this authorization is voluntary. I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed.
- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and I can initiate the process by contacting the privacy officer at 828-433-1000.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the federal Privacy Standards.
- I understand that I have the right to receive a copy of this authorization after it is signed.
- I understand that Morganton Eye Physicians, PA may charge a fee to cover the copying and/or postage expense incurred for the release of my records.

Acknowledged and agreed to by the individual/patient to whom the protected health information pertains, or by the patient's representative, who is empowered to act on his/her behalf.

Patient Name (printed): _____ Signature _____

Patient Representative's Name (printed) _____ Signature _____

Relationship (parent, legal guardian, Power of Attorney, etc) _____

Date _____