

Asheville Associates

Authorization For The Use Or Disclosure Of Medical Records

I authorize Asheville Eye Associates, PLLC to use or disclose my medical information. (Protected Health Information)

I _____
(Patient Name-Printed) (Patient Date of Birth)

Patient or Responsible Party EMAIL: (Will be added to PATIENT account) Please PRINT Legibly

AUTHORIZE: _____

Address: _____

Phone#: _____ Fax#: _____

TO RELEASE MY RECORDS TO: _____

Address: _____

Phone#: _____ Fax#: _____

My authorization applies to the following (check all that apply):

- All medical records (include visual fields)
- Clinical Notes
- Contact Lens, including original K's.
- Only information necessary to complete the form is provided.
- Lab/Imaging Results
- Only information on the following dates/conditions: _____
- Other (specify): _____

My protected health information will be used or disclosed upon request for the following purposes.

- (check all that apply): Personal records Continued medical care Insurance claim
 Other (specify): _____

This authorization expires one year from the date below or on: _____

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing addressed to **Privacy Officer c/o Asheville Eye Associates, PLLC**. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from **Asheville Eye Associates, PLLC** nor will it affect my eligibility for benefits.

I understand that I have a right to inspect and receive copies of my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of the authorization.

Patient Signature

Date

Name of Personal Representative (if applicable)

Relationship to Patient (if applicable)

****RETURN FOR PROCESSING:** 8 Medical Park Dr. Asheville, NC 28803

Fax: 828-258-1765 **Email:** mr@aea1961.com

