Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip: _____

Purpose of Request: ☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other: _____

Information to be Release: *clinical records relating to eyecare*

☐ Most recent visit/encounter ☐ All visits/full record, including Optos

☐ Date of service range (month/year): _____ to _____

Authorize Release of Information to: Optimal Eyecare, P.C.

Office:	☐ Broomfield	☐ Northglenn
Address:	1285 E. 1st Ave, Ste D Broomfield, CO, 80020	10669 Melody Dr Northglenn, CO 80234
Phone:	(303) 464-7627	(303) 452-9312

E-Fax: (720) 684-5682

Request Timeline: ☐ Urgent (same day) ☐ Standard (five business days)

Send to secure email:
DrAdler@optimal-eyecare.com

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary, and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure healthcare treatment.

I request this authorization to expire on _____ or 180 days from the date signed below, covers only treatment for the date(s) specified above.

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED.

_____ _____

Signature of patient or legal representative Date