THE EYE CENTER

MEDICAL & SURGICAL EYE CARE

120 Medical Blvd., Suite 101, Spring Hill, FL 34609
Phone: 352-683-4500 Fax: 352-683-2210

HIPAA Release of Information

Patient authorization for use and disclosure of protected health information (PHI) for purposes requested by the practice

Name: _____ Date of Birth: _____/_____/_____
(Please Print)

By signing this authorization, I authorize The Eye Center to release/disclose my medical information, medical history, progress notes with diagnosis, laboratory data, imaging studies and claims information. This information may be released to:

[ ] My Spouse/Partner: _____
Name

[ ] My Child(ren):_____
Name(s)

[ ] Other: _____
Name(s)

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing. My written revocation must be submitted to The Eye Center, 120 Medical Blvd Ste 101, Spring Hill, FL 34609.

I do not have to sign this authorization in order to receive treatment from The Eye Center. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed By: _____ Date: _____/_____/_____
Signature of Patient or Legal Guardian