New England College of Optometry

CENTER FOR EYE CARE

Authorization for Use & Release of Health Information

Patient Name_____ Date of Birth_____ Date_____

Address:_____

Patient Phone Number_____

I authorize the New England College of Optometry Center for Eye Care and New England College of Optometry Clinical Network (together referred to as "New England College of Optometry") to disclose or request my protected health information to the person or class of persons listed below.

Enter where you would like information sent from, and to whom you would like the information to be sent.

FROM: (e.g. hospital, clinic, or provider name):	**TO:** (e.g. To whom you would like the information sent)
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Tel #: _____	Tel #: _____
PURPOSE: (Check the appropriate box) * Copying fees may apply	**SEND BY:**
□ Medical Care □ Personal	□ Paper Copy via Mail
□ Insurance* □ School	□ Secure E-Mail (provide E-Mail address here_:
□ Legal Matters* □ Other (please specify):	_____
_____	□ Fax (provide Fax # here): _____

Type of Medical Records Requested:

□ Notes from most recent eye examination □ Entire clinical record
□ Most recent contact lens fitting examination/prescription (required for specialty contact lens fittings)
□ All eye care exam notes within the last 12 months □ Other: _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

- □ Alcohol/Drug Abuse Treatment/Referral
- □ Sexually-Transmitted Diseases
- □ Details of Domestic Violence Victim's Counseling
- □ Details of Sexual Assault Victim's Counseling
- □ Communication between Patient and Social Worker
- □ Details of Mental Health Diagnosis/Treatment provided by Licensed Mental Health Clinician
- □ HIV/AIDS Diagnosis and/or Treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release_as required by M.G. L. c.111, § 70F.
- □ Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release as required by M.G. L. c.111, §70G.

Authorization Agreement

- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- This authorization is voluntary.
- I decline the opportunity to inspect or copy the information released.
- My questions about this authorization form have been answered.
- I understand that I may revoke this authorization at any time by notifying New England College of Optometry Center for Eye Care/New England Eye in writing and that if I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.
- This authorization will expire 12 months from fulfillment of the request unless I specify a different expiration date or expiration event here:

  _____.

_____ _____

Signature of Patient or Personal Representative Relationship if signed by Personal Rep.

_____ _____

Print Name Date

Return completed form to: **Medical Records Department, NECO Center for Eye Care, 930 Commonwealth Ave. Boston, MA 02215 or fax to: 617-236-6323.** If any questions about this form, please call: 617-262-2020.