

Authorization for Use and Release of Health Information

Patient name _____ Date of Birth _____
 Address _____
 Patient Phone Number _____ Today's Date _____

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 sent to.

| | |
|---|---|
| FROM (e.g. hospital, clinic, or provider name): | TO: (e.g. To whom you would like the information sent) |
| Name | Name |
| Address | Address |
| Phone | Phone |
| PURPOSE: (Check the appropriate box) * Copying fees may apply <input type="checkbox"/> Medical Care <input type="checkbox"/> Personal <input type="checkbox"/> Insurance* <input type="checkbox"/> School <input type="checkbox"/> Legal Matters* <input type="checkbox"/> Other _____ | SEND BY: <input type="checkbox"/> Paper Copy via Mail <input type="checkbox"/> Secure E-Mail (must sign E-Mail consent form), e-mail address _____ <input type="checkbox"/> Fax # _____ |

Types of Medical Records requested

| | |
|---|--|
| <input type="checkbox"/> Notes from most recent eye examination <input type="checkbox"/> Most recent contact lens fitting examination/prescription <input type="checkbox"/> All eye care exam notes within the last 12 months | <input type="checkbox"/> Entire clinical record < 3 examinations (free) <input type="checkbox"/> Entire clinical record > 3 examinations (\$15 fee to patient) <input type="checkbox"/> Other: _____ |
|---|--|

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

| | |
|--|---|
| <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Details of Domestic Violence Victim's Counseling <input type="checkbox"/> Details of Sexual Assault Victim's Counseling <input type="checkbox"/> Communication between Patient and Social Worker <input type="checkbox"/> Details of Mental Health Diagnosis/Treatment provided by Licensed Mental Health Clinician | <input type="checkbox"/> 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.III, § 70F. <input type="checkbox"/> 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.III, § 70G. |
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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 understand that there is a \$15 charge if a request of an entire record (records outside of 1 year) are made.**
- 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/event here _____.

Signature of Patient or Personal Representative

Relationship if signed by Personal Rep.

Print Name

Date