PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (Print Clearly): _____ Patient Date of Birth: _____

I authorize Verdier Eye Center, PLC and / or East Paris Surgical Center, LLC to disclose or provide **Protected Health Information (PHI),** about me to the individual(s) listed below.

Name	Relationship	Phone
_____	_____	_____

☐ I grant the person listed above **full** access to my entire patient record / PHI; or check **only** those items of the record to be disclosed:

- □ Office Notes
- □ Financial History Report
- □ lab results, pathology reports
- □ x-rays
- □ Nursing home, home health, hospice, & other physician records
- □ Record of mental health or substance abuse treatment
- □ Record of HIV and communicable disease testing
- □ Other: _____

Name	Relationship	Phone
_____	_____	_____

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- □ Record of mental health or substance abuse treatment
- □ Record of HIV and communicable disease testing
- □ Other: _____

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue authorization. Please list the date of expiration if earlier than the end of the calendar year: _____

_____ _____

Patient or Authorized Person Signature Date