Mid-Atlantic Eye Care

AUTHORIZATION FOR RECORDS DISCLOSURE

Patient name: **Birthdate:**
Mid-Atlantic Eye Care ID Number: **SSN:**

Our practice	**CIRCLE ONE**	**Other person/organization**
Mid-Atlantic Eye Care		
109 Wimbledon Square, Suite E	provided TO this other -	
Chesapeake, VA 23220	**or**	
Fax (757) 466-7616	provided FROM this other -	

Specific description of information (including dates):

The information described above will be used or disclosed for the following purpose(s):

Expiration date or event:

I hereby authorize the use or disclosure of my protected health information as described above. Fees may apply.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: the Privacy Officer at Mid-Atlantic Eye Care, 109 Wimbledon Square, Suite E, Chesapeake, VA 23220. Any revocation will not affect disclosures made prior to Mid-Atlantic Eye Care's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form. Fees may apply.

I certify that I have received a copy of this authorization.

Signature of patient or patient's representative: **Date:**

Printed name of patient's representative:

Relationship to the patient: