Carolina Ophthalmology, P.A.

HIPAA Authorization for Release of Protected Health Information

Patient Name _____ Home Phone Number _____

Date of Birth _____ Guardian or Authorized Party Name (if applicable) _____

I authorize the use and disclosure of my health information as described below.

Information Requested:

____ Records relating to treatment dates from: _____ to _____

____ Records for all care at this facility or by doctor(s) _____

____ Other (Please specify) _____

Term: I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing. Without my express revocation, this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards. I further understand that Carolina Ophthalmology may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Check here ☐ if you plan to pick up these records. Please note there is a charge to copy medical records (see below). We will call you at the above number when the records are ready to be picked up.

Information to be released ☐ from ☐ to
(*Please check one)*

Recipient or Sender's Name and Address

_____

_____

_____

_____

Phone *Fax*

☐ from ☐ to
(*Please check one)*

Carolina Ophthalmology, P.A.
1701 Old Village Road
Hendersonville, NC 28791
(828) 693-1773 phone
(828) 692-3297 fax

_____ _____

Signature of Patient or Guardian** **Date**

**If this authorization is signed by an individual's personal representative, the representative's authority is based on: _____ (e.g., state law, court order, POA, etc.)

A fax copy or photocopy of this consent shall be as valid as the original.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee to copy records is $0.75 per page for the first 25 pages, $0.50 per page for additional pages up to 100, and $0.25 for each additional page in excess of 100. No fee shall be charged for reproducing and forwarding records directly to other physicians.

NOTE: Please allow a minimum 2-4 weeks for records to be copied. We will prioritize emergency requests when possible.