Patient Authorization for Release/Disclosure of Protected Health Information

Patient Name (print)_____ **Date of Birth** _____

Address _____ **City/State** _____ **Zip** _____

I authorize the release of my health information From:	**I authorize the Release of my Health Information to:**
Provider/Office:	**Aly Sheraly / Orlando North Eye Clinic**
Address:	**3300 W Lake Mary Blvd, Suite 210** **Lake Mary Fl, 32746**
Phone/Fax:	**(321) 234-7424** **(866) 388-3867**

☐ **ALL** my health information maintained
☐ My health information for the date(s):_____
X Other: Current and previous treated Medical Conditions, surgical history, allergies, medication list

Requested for Treatment. This authorization remains in effect until the requested information has been received.

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: ☐Alcohol/Drug ☐Behavior/Mental Health/Psychiatric ☐Sexually Transmitted Disease ☐HIV/AIDS ☐Other; specify exclusion ____

I understand that I have the right to request that a service for which I have paid out---of---pocket, not be disclosed to my health plan.

SIGNATURE: _____ **PRINT NAME:** _____ **DATE:** _____

Patient /Guardian/Parent/Patient's Representative

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REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form, my medical (healthcare) treatment and insurance benefits will not be affected, however, my medical records **CANNOT** be released. I understand that I may revoke this authorization at any time by notifying the organization in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.