MIDWEST EYE INSTITUTE

ESTABLISHED 1982

AUTHORIZATION

FOR RELEASE/USE/DISCLOSURE OF HEALTH INFORMATION

This form should not be completed unless the patient agrees to a PHI release. If release of the patient's PHI to anyone other than the referring physician is not required, this form is not required.

Dear Patient,

This form is OPTIONAL. It is to be used in the event that either the patient, or the treating physician, has a specific desire or need to release all or any portion of a patient's protected health information (a/k/a PHI)/medical record to any persons or organizations not already involved with the patient's care.

If you do not wish to have any of your medical information shared with anyone other than the physician that referred you to Midwest Eye Institute, YOU DO NOT NEED TO COMPLETE THIS FORM.

This form is included with a new patient's paperwork in order to provide an opportunity for a patient to provide authorization for the Midwest Eye treating physician to share their PHI to a guardian; other family members; non-referring physician(s); and/or other parties.

Patient Name: _____ Date of Birth: _____

Name of your Midwest Eye Physician: _____

Name of Person(s) and/or Organization(s) authorized to receive information:
[Include anyone you want to have information about the treatment you receive at Midwest Eye]

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

Limitations to this Authorization must be identified below. If this portion of the form is left blank, it is assumed that the information authorized for released is unrestricted. Please describe below any restrictions you wish to place on this authorization. [Restrictions might include limitations as to type of information released; specific dates or period of time involved; or a specific purpose for which the release might apply.]

_____

_____

_____

[Form continues to reserve side]

As a patient I understand and accept the following statements:

I may see and copy the information described on this form if I ask for it, and I can receive a copy of this form after I sign it if I request one.

Patient Initials _____

If my physician has initiated this Authorization, I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I may not be able to get that treatment without signing this form

Patient Initials _____

I hereby authorize the release / use / disclosure of my individually identifiable health information (a/k/a Protected Health Information of PHI) as described above. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice or Midwest Eye Institute, the released information may no longer be protected by federal privacy regulations.

Patient Initials _____

[Note: If the patient is unable to sign for themselves and is underage, or if there is a Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as "patient representative" If this Authorization has been initiated by anyone other than the patient, their legal guardian or the patient's authorized representative, the patient may refuse to sign this Authorization.]

_____Date: _____

SIGNATURE OF PATIENT, LEGAL GUARDIAN, OR PATIENT REPRESENTATIVE

PRINTED NAME OF GUARDIAN OR REPRESENTATIVE: _____

As appropriate, describe guardian's or representative's relationship to patient: _____

Witness: _____ **Date:** _____

[Witness if required if someone other than the patient is signing on behalf of the patient.]

Expiration date (optional): Patient can set an expiration date for this Authorization in this space.
This authorization will expire on: ____ / ____ / _____ (MM/DD/YY) or on the occurrence of the following event:

_____

_____

REVOCATION (optional): This authorization may be revoked at any time by notifying your Midwest Eye Physician in writing at:

Dr. _____
C/O Midwest Eye Institute
10300 North Illinois St., Suite 1000
Indianapolis, IN 46290

If I, as a patient or patient representative, do revoke this authorization, I understand that action will not apply to activity that occurs before the Revocation is received.