M c C A N N E L E Y E S U R G E R Y

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient name: _____ DOB: _____
Address: _____
Phone: _____ Cell: _____

I authorize McCannel Eye Surgery to:

- ☐ request my medical records FROM:
- ☐ disclose my records TO:

Individual / Entity name: _____
Address: _____
Phone: _____ Fax: _____

The following information is to be released:

- ☐ Previous 1 year of entire patient record, OR check only those items below to be disclosed:
  - ☐ Office notes
  - ☐ Lab tests
  - ☐ Financial history
  - ☐ Other: _____

I am requesting this information to be released for the following reason:

- ☐ Continuation of care
- ☐ Attorney review
- ☐ Personal use (please enclose $0.75 + tax per page payment; $20 max)
- ☐ Other: _____

This authorization will expire 1 year from the date signed unless you specify an earlier termination. (List date if earlier than 1 year: _____) You must submit a new authorization form after the expiration date to continue the authorization.

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.

McCannel Eye Surgery places no condition to sign this authorization on the delivery of healthcare.

McCannel Eye Surgery has no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of McCannel Eye Surgery.

_____ _____
Patient or authorized representative signature Date