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www.ChapelHillEye.com

Authorization to Disclose Protected Health Information

I authorize ____ to disclose the Protected Health Information requested below to: **CHAPEL HILL OPHTHALMOLOGY CLINIC, P.A.**

Information to be disclosed :
____

____

This information will be used for the following purpose:____
(at the request of the individual is sufficient)

This authorization shall be in force and effect until ___________________________ at which time this authorization to disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Chapel Hill Ophthalmology Clinic, 110 Conner Drive, Suite 2, Chapel Hill, NC 27514.
I understand that a revocation is not effective if my authorization was obtained as a condition of obtaining insurance.

I understand the Protected Health Information disclosed pursuant to this authorization may be further disclosed by the recipient of the information and, if that occurs, the information my then no longer be protected.

I understand that Chapel Hill Ophthalmology Clinic will not condition my treatment on whether I provide authorization for the requested disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party.

____ ______________________ ________________
Signature of Patient or Personal Representative **Patient Date of Birth** **Chart Number**

____ ______________
Print Name of Patient or Personal Representative **Date**

____ ______________
Witness **Date**

Patient Address: ____

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