RealEyes Vision Center

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AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____
Name of Patient (Please Print) Date of Birth

_____ _____
Street Address City/State/Zip Phone

I hereby authorize (Please Print) To release to: (Please Print)

_____ _____
_____ _____
_____ _____

The following information from my records:

☐ Complete Health Record(s) ☐ History & Physical ☐ Radiology Report
☐ Operative Report ☐ Laboratory Report ☐ Pathology Report
☐ Only Health Records from Dr(s)_____
☐ Other (please specify)

Covering the period from _____ to _____

_____(initial) I understand that this authorization will include information to:

- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- Psychiatric care
- Treatment for alcohol and/or drug abuse
- Genetic testing

If any, except as specifically stated here:_____
This information is to be disclosed for the purpose of _____
The date, extent or condition upon which this authorization expires is _____ (not to exceed 24 months). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the date noted above.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than RealEyes Vision Center and Michael D. Tschoepe, M.D. and therefore is responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by RealEyes Vision Center and Michael D. Tschoepe, M.D. concerning me, including incorporated records. I acknowledge that RealEyes Vision center and Michael D. Tschoepe, M.D. has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release RealEyes Vision Center and Michael D. Tschoepe, M.D. and its personnel from all legal responsibility that may arise from the act I have authorized above. RealEyes Vision Center and Michael D. Tschoepe, M.D. is not responsible for completeness, legibility, or omissions caused by the coping of any medical records from another institution.

_____ _____
Signature of Patient, Parent, or Authorized Person Date

_____
Printed name of patient's representative

_____
Relationship to patient

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined or imprisoned.