WHITE EYE ASSOCIATES PA
OPHTHALMOLOGY
301 BOWMAN GRAY DRIVE ■ GREENVILLE, NC 27834
(252) 758-5800 ■ (800) 682-2493
FAX (252) 758-3508

Authorization for Use or Disclosure of Health Information

Patient's Full Name (*please print*): _____

Patient's Date of Birth: _____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Records Request (Specific Description of the Information to be Used or Disclosed)**:**

☐ Complete health record(s), including all images (x-rays, photographs, etc.)

OR

Select from the following (check as many as apply):

____ Discharge Summary
____ History and Physical Examination
____ Mental health care or services
____ Psychotherapy Notes
____ Treatment for alcohol and/or drug abuse
____ Photographs, videotapes, digital or other images
____ AIDS (Acquired Immunodeficiency Syndrome or HIV (Human Immunodeficiency Virus) infection
____ Progress Notes
____ Laboratory Tests
____ Consultation Reports
____ X-ray reports

☐ Other: _____

The above information will be referred to as "Authorized Information" hereafter.

Request Records From (Person/Class of Persons Authorized to Make the Use or Disclosure)**:**

☐ White Eye Associates, PA ■ 301 Bowman Gray Drive ■ Greenville, NC 27834

☐ Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Send Records To (Person/Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made)**:**

☐ White Eye Associates, PA ■ 301 Bowman Gray Drive ■ Greenville, NC 27834

☐ Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Purpose of Records Request (Authorized Information will be used and/or disclosed for the following purpose(s))**:**

☐ At the request of the individual

☐ Other (*please specify*): _____
_____

■ I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by the federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

■ I understand that I may revoke this authorization at any time by **White Eye Associates, P.A.**, in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by **White Eye Associates, P.A.**, before receiving my revocation.

■ I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
[*Alternative, if applicable*]: I understand that **White Eye Associates, P.A.**, may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that **White Eye Associates, P.A.**, will not provide such research-related treatment unless I provide this authorization. **NOTE:** If this provision is applicable, the third party for whom the information is being created must be listed under "Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made." Also, the purpose for which the information is to be created and disclosed must be listed under "Authorized Information will be Used or Disclosed for the Following Purposes."

■ [*For Marketing Authorizations, ONLY, if applicable*] I understand that the person or entity I am authorizing to use and/or disclose Authorized Information for marketing purposes may receive either direct or indirect compensation for doing so.

White Eye Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization expires on _____ OR the date the following event occurs:
date

_____
(describe event or write "not applicable")

Patient's Signature_____ **Date:** _____

For Personal Representative of the Patient (*if applicable*):

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature: _____ Date: _____

Name of Personal Representative (*please print*): _____

Relationship to Patient *(i.e. parent, guardian, power of attorney, etc.)* : _____