Authorization to Release and Obtain Health Information

Patient's Full Legal Name:_____Date of Birth:_____
Social Security Number: XXX-XX-_____Phone Number: _____

COMPLETE the appropriate section below to SEND OR GET health information.

PLEASE SEND HEALTH INFORMATION TO: (Where do you want the information sent?)	**PLEASE GET HEALTH INFORMATION FROM:** (Who has the information you want released?)
Name of Patient/Guardian/Provider/Clinic/Organization	Name of Provider/Clinic/Organization
Street Address	Street Address
City State Zip Code	City State Zip code
Phone Fax	Phone Fax

RECORDS to be: _____mailed _____Picked up_____Faxed

If sending information to guardian, please list relation to patient_____

I AUTHORIZE the following information to be disclosed (mark those that apply):

_____ Any and all records in the possession of Somerset Ophthalmology including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released).

_____ Records regarding treatment for the following condition or injury _____

_____ Records covering the period of time from _____ to _____.
REASON for disclosure of health information:

_____personal use _____Legal _____Insurance _____Disability _____ Other:_____ **ADDITIONAL PATIENT INFORMATION**

I understand that I have the right to revoke this authorization in writing at any time by sending such notification to Privacy Officer, Somerset Ophthalmology, 2877 Crooks Rd., Ste. B., Troy, MI 48084. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. This authorization expires six months from the date of the signature. A copy of this authorization will be provided to me upon request.

_____ _____
Signature of Patient or Representative Date