Tel. 603.668.2020 • Fax 603.668.0881
250 River Road, Manchester, NH 03104 • 407 Riverway Place, Bedford, NH 03110
835 Hanover Street Suite 304, Manchester, NH 03104 • 17 Riverside Street Suite 104, Nashua NH, 03062

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ____ Date of Birth ___________________________

I hereby authorize that you release and disclose my health information as described below:

Information Requested:

______ Records relating to treatment dates from: ______________ to: _____________

______ Records for all care at this facility or by this doctor.

______ Other (Please Specify) ____

[ ] from [ ] to The Medical Eye Center, P.C.

[ ] from [ ] to _____________________________________

____

____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must send such written notification to the Practice's Privacy Officer. I understand that when my information is used or disclosed pursuant to this authorization that it may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule.

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified (insert date): ____________________________________

____ __________________________________

Signature of Patient or Guardian** **Date**

A fax copy or photocopy of this consent shall be valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions,
I DO _______ DO NOT _______ authorize the release of this information.

**If this authorization is signed by an individual's personal representative, the representative's authority is based on:
____ (e.g., state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. I may be subject to a fee of $15.00 for the first 30 pages and $.50 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

For office use only:
Physician Authorization ____ Date sent: ________________ By: ___________