



Authorization to Release Protected Health Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

VIRGINIA EYE INSTITUTE is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Appointment reminders and test results can be left on my answering machine Yes No

Medical and Financial information may be given to my spouse. Yes No

Other \_\_\_\_\_ Relationship \_\_\_\_\_ Yes No

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices for the above named practice. I understand that I may ask questions to the Virginia Eye Institute if I do not understand any information contained in the Notice of Privacy Practices.

Signature of Patient or Personal Representative (relationship to patient) Date
Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

We were unable to obtain a written acknowledgement of the above because:

- An emergency existed & a signature was not possible at the time.
The individual refused to sign.
Unable to communicate with the patient for the following reason:

Prepared By: \_\_\_\_\_ Date: \_\_\_\_\_