THE EYE CLINIC OF MONROE, AMC
AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. I, _____, hereby authorize _____ to disclose the following protected health information to:
   _____
   _____

2. The specific information subject to this authorization is:

   ☐Necessary Medical Records Determined by the Physician
   ☐Operative Reports
   ☐Diagnostic Testing
   ☐Health History Form
   ☐Lab/Special Reports
   ☐Consent Forms
   ☐Examination Forms
   ☐Entire Medical Record
   ☐Other
   ☐Insurance
   ☐Photographs
   ☐Optical Information

   _____
   _____

3. This protected health information is being used or disclosed for the following purposes:
   _____
   _____

4. This authorization shall be in force and effect until_____, at which time this authorization to disclose this protected health care information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to this Health Care Provider. I understand that a revocation is not effective:
   a. to the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or
   b. if the authorization is obtained as a condition of obtaining insurance coverage, if some other law or the policy itself provides the insurer with the right to contest a claim under the policy.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. I understand that this Health Care Provider may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide this authorization for the requested use or disclosure.

8. I understand that I have the right to:
   a. Inspect or copy the protected health information to be used or disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights, and
   b. Refuse to sign this authorization.

_____ _____ _____
Signature of Patient or Representative | Print Name of Patient or Representative | Date

_____ _____
Date of Birth | Social Security Number