Eye Physicians and Surgeons, P.A.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Part 1: **Name of person whose health information will be disclosed:**

Part 2: **Person or Entity that has the health information to be released:**

Health Care Provider: _____

(Print the name and address of the provider that has the record to be disclosed, e.g., Dr. Jane Doe, ABC Laboratories, XYZ Hospital, etc. If you need to list more than one health care provider, please provide an extra page with that information.)

Part 3: **Description of the health information to be released:**

My health information and medical records related to the request of reasonable accommodation(s).

Other: _____

(Describe health information that may be disclosed. Medical diagnosis is not requested.)

Part 4: **Person or Entity that will receive the health information:**

Part 5: **Description of the purpose for the release of the health information:**

To support my request for:

Part 6: **Duration of Authorization:** This authorization will remain effective until the earlier of (choose an expiration period):

Expiration period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ ___days

Part 7: **Certification and Acknowledgement:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5.

I understand that the health care provider(s) listed in Part 2 will not condition treatment, payment, enrollment or eligibility on the provision of this Authorization. However, I understand that my request may fail to process if I do not sign this Authorization and provide my health information that is necessary to support my request.

I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity authorized to release the information in Part 2, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization.
I also understand that, if I revoke this Authorization and therefore do not provide the releasee with the information necessary to support My Request, the releasee may deny My Request.

I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal HIPAA privacy rules. However, I also understand that the recipient will protect my health information in accordance with other applicable laws and the State of Delaware's internal privacy policies. ***I have received a copy of my signed Authorization.***

Signature: _____ **Date:** _____

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:

Name: _____

Authority: _____