Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name:_____ Account #:_____
SSN (last four digits): _____ Date of Birth:_____

Family Eye Group
2110 Harrisburg Pike, Suite 215 **Phone: 717-299-9232**
Lancaster, PA 17601 **Fax: 717-299-6532**

Disclose or Obtain (please circle choice)

Protected health information about me to or from the individual listed below:

Facility/Individual Name:_____
Address: _____
_____
_____
Phone:_____ Fax:_____

Description of information to be disclosed or obtained – I authorize Family Eye Group to disclose or obtain the following protected health information about me to the facility or individual identified above.

- o Entire patient record, or check only those items of the record to be disclosed:
- o Office Notes
- o Lab Results, Pathology Reports
- o X-rays
- o Financial History Report (previous 3 years only)
- o Only send the following: _____

Purpose of disclosure

- o Patient Transferring Care
- o Patient Discontinuing Care
- o Second Opinion
- o Patient Relocating
- o Other (please specify):_____

- This authorization will expire at the end of the calendar year of your last signature below. Unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where disclosure has already been made based on prior authorization
- The practice places no condition to sign this authorization on the delivery of the healthcare treatment.
- We have no control over the person(s) you have listed to disclose or obtain your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative signature _____ date _____
Patient or representative signature _____ date _____