Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated

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

Family Eye Group, P.C., 2110 Harrisburg Pike, Suite 215, Lancaster, PA 17601
Phone: 717-299-9232
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, P.C. to disclose or obtain the following protected health information about me to the facility or individual identified above.

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

Purpose of disclosure

____ Patient Transferring Care
____ Patient Discontinuing Care
____ Second Opinion
____ Patient Relocating
____ 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 healthcare of treatment.

We have no control over the person(s) you have listed to receive 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 Family Eye Group, P.C.

_____ _____
Patient or Authorized Representative Signature Date