Deer Eye Clinic

4942 West Markham
Little Rock, Arkansas 72205
Phone: (501)224-4701 Fax: (501)224-1003

HIPAA-COMPLIANT PHI RELEASE FORM

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) *to disclose* my protected health information (as specified below):

   Name(s)/ Organization(s) _____

   Address _____

   Phone _____ Fax_____

2. I authorize the following person(s) and/or organization(s) *to receive* my protected health information, as disclosed by the person(s) and/or organization(s) above.

   Name(s)/ Organization(s) _____

   Address _____

   Phone _____ Fax_____

3. Specific description of the protected health information that I authorize for disclosure:

   _____

4. Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space:
   _____

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. An authorization must be signed each and every time the patient requests private health information to be disclosed.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____
Signed Date

Name _____

Address _____

Telephone _____ Date of Birth _____

_____
Relationship or Authority of Personal Representative (if applicable)