THE EYE CENTER
AT SOUTHERN COLLEGE OF OPTOMETRY

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME:______________________________ BIRTHDATE:____

ADDRESS:____________________________________ CITY:____________________________ ZIP CODE:______________

SOCIAL SECURITY#:___________________________________ PHONE NUMBER:________________________________

I authorize The Eye Center at Southern College of Optometry to: *(Check One)*

❑ **Disclose** my protected health information to:

____
Name

____
Mailing Address

____
City State Zip

***If address is incomplete, requested information will be mailed to patient.**

❑ **Request** copies of my protected health information **FROM:**

____
Name

____
Mailing Address

____
City State Zip

Specifically covering treatment from (*specify dates or event*):____________________ to:____________________.

Purpose of use and/or disclosure of protected health information:____

____

Specify type of information to be used and/or disclosed:
❑ Exam Summary
❑ Exam Notes
❑ Tests/Results (*Please Specify*):____
❑ Prescription
❑ Other (*Please Specify*):____

This authorization is valid for six (6) months after the date it is signed, unless an earlier expiration date or specific event is indicated here: ________________________________

RIGHTS

- I have a right to receive a copy of this Authorization.
- I have a right to revoke this authorization at any time by submitting a written request, signed by the patient or patient's legal representative, to the Privacy Officer at The Eye Center @ Southern College of Optometry. I am aware that my revocation is not effective to the extent that the person(s) I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I do not have to sign this Authorization and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.
- I understand that if the person(s) authorized to receive the information is not a health plan or health care provider, the released infor mation may be re-disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.
- I understand that a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing to anyone other another health care provider.

____ ______________________________
Signature of Patient or Patient's Representative Date

____ ______________________________
Printed Name Patient or Patient's Representative Relationship to Patient

____ ______________________________
Witness Date

Fax to: ____ *or Mail to:*
1225 Madison Ave., Memphis, TN 38104