PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Records Request
Renewed Vision

1681 Old Pendergrass Road, Ste 170, Jefferson, Ga, 30549, (706) 387-0111, Fax: (706) 367-1290
Privacy Officer: EM Jones

Patient's Full Name_____ DOB_____

By signing this authorization, I authorize_____
to use and/or disclose certain specific protected health information to : **Renewed Vision**

1. What PHI may be used or disclosed: (This Authorization permits the authorized party to use or disclose the following PHI):

- ❑ Copy of most recent examination, including Medical History
- ❑ Copy of most recent diagnostic tests
- ❑ Copy of most recent prescriptions
- ❑ _____

2. The specific purpose for which I authorize the disclosure of this PHI is:

_____

(May state: "at the request of the individual" if the individual is initiating the Authorization and elects not to provide a statement of purpose)

3. I understand that this authorization is valid until (check one):
□ today's date □ 1 month from today □ 6 months from today □ 1 year from today □ other _____/_____/_____.

4. I expressly acknowledge that this authorization is voluntary. I understand that this authorization may be revoked by the authorizer, in writing, at any time by contacting the Privacy Officer at the address above. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

5. This authorization is valid as of _____/_____/_____ (today's date).

_____ _____
Name of Individual/Patient (printed) Signature of Individual/Patient

_____ _____
Signature of Legal Representative if necessary (e.g., Attorney-In-Fact, Guardian, Parent if minor) Relationship

Witness:_____