



AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION
(Authorization to release patient's records from our office)

I _____ hereby authorize Rocky Mountain Eye Center, P.C. to release my medical records to:

 (Name)

 (Address)

 City, State, Zip Code

I intend for Rocky Mountain Eye Center, P.C. to release the following information (Check One)

- All healthcare information in its possession, whether generated by Rocky Mountain Eye Center, P.C. or transferred from other sources.
- Only healthcare information generated by Rocky Mountain Eye Center, P.C.

Unless specified otherwise, we do not routinely release supplemental information such as visual field tests, fundus photographs, fluorescein angiograms, A- or B-scans, and X-rays. If you want us to release any of these items, please check the appropriate boxes. **PLEASE NOTE THAT RELEASE OF THESE ITEMS MAY INCUR A CHARGE FOR DUPLICATION.** Fees for duplication will be provided upon request, and are in conformance with provisions of MCA §50-16-526:

- Visual Field tests Fundus photographs Fluorescein angiograms X-rays
- A-scans/B-scans Other (please specify) _____

If there is specific information you **DO NOT** want us to release, please specify by checking the box:

- Records generated by other providers AIDS or HIV-related information
- Alcohol or drug treatment information Other (specify): _____
- Mental-health information

Dates of Service To Be Released: From _____ To _____

For the purpose of: ___ legal ___ insurance ___ evaluation and treatment Other: _____

Revocation

This authorization is subject to revocation at any time by giving written notice to the Privacy Officer as indicated in the Notice of Privacy Practices. The revocation is effective from the time it is received by Rocky Mountain Eye Center, P.C. and does not apply to actions taken by Rocky Mountain Eye Center, P.C. prior to that.

Expiration

If not revoked, this authorization terminates thirty months from the date of its execution, or on _____.

Acknowledgments

I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization as a condition of receiving treatment from Rocky Mountain Eye Center, P.C. unless my treatment is research related or purpose of treatment is to generate information for a third party.

 Patient Name (Please Print)

 Date of Birth

SS# _____ - _____ - _____

 Signature of Patient or Patient's Representative

 Relationship to Patient

 Date