

EYE PHYSICIANS OF CENTRAL FLORIDA
A Division of Florida Pediatric Associates, LLP

AUTHORIZATION TO USE OR DISCLOSE

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Security Number: _____ - _____ - _____

SECTION A: Please read and complete the following statements carefully.

No Conditions: This authorization is voluntary. We will not condition your treatment on your giving this authorization.

Purpose of this Authorization: By signing this form, you authorize Provider to use and/or disclose your protected health information for the following purposes:

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Protected Health Information to Be Used and/or Disclosed: The specific protected health information we are asking you to authorize us to use and/or disclose for the purposes stated above is:

Inspection and Copy of the Protected Health Information: You have the right to inspect and/or copy the protected health information described above.

Entities Authorized to Receive and Use: The persons and/or organizations (or the classes of persons and/or organizations), to whom you are authorizing Provider to disclose and/or let use the protected health information described above are:

To: _____

From: _____

SECTION B: Remuneration (check one).

Provider will not receive direct or indirect remuneration from a third party as a result of the use and/or disclosure of the protected health information requested by this authorization.

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SECTION C: Expiration and Revocation.

Expiration: I hereby understand that this authorization allows Eye Physicians of Central Florida, P.L.C. to release one copy of my medical record to _____. This authorization expires either thirty (30) days from the date of my signature, or upon the date that Eye Physicians of Central FL, P.L.C. provides the copy of my medical records.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Eye Physicians of Central Florida, P.L.C.
790 Concourse Parkway South, Suite 200
Maitland, FL 32751

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form for the purposes stated in this form.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.