Established 1971
HOUSTON EYE ASSOCIATES™

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ HEA Physician: _____

Date of Birth: _____ HEA Location: _____

Email Address: _____

I authorize **HOUSTON EYE ASSOCIATES** to ***SEND*** records to:	I authorize **HOUSTON EYE ASSOCIATES** to ***RECEIVE*** records from:
Person/Organization: _____	Person/Organization: _____
Address: _____	Address: _____
_____ _____ _____	_____ _____ _____
City State Zip Code	City State Zip Code
Phone #: _____	Phone #: _____
Fax #:_____	Fax #:_____
Send by: ___ Download ___ Fax ___ Mail	Send by: ___ Fax ___ Mail

Date Range of Requested Records: _____ to _____

PURPOSE OF DISCLOSURE: ___ Continued Medical Care ___ Patient Request
___ S.S. Disability Determination ___ Other (please describe):_____

Please release the following:
___ Past 12 months ___ All available records
___ Other (please describe): _____
___ Entire record ***excluding***— HIV Testing & Chemical Dependency

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, or condition, this authorization will expire in 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or have a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer with HOUSTON EYE ASSOCIATES at 2855 Gramercy St., Houston, Texas 77025.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to patient (If Legal Representative) Date

MAIL to:2855 Gramercy St., Houston, Texas 77025
Tel: (713) 668-6828 **Fax**: (713) 668-2158