

CAPLAN EYE CLINIC

3409 North Hullen St. Metairie, LA 70002 504-888-2600 fax: 504-456-9596
4700 Highway 22 Mandeville, LA 70471 985-845-3400 fax: 985-845-9463

Patient Name _____ Date of Birth _____

Medical Record Number _____ (for office use)

PATIENT AUTHORIZATION FOR USE/RELEASE OF INFORMATION

I _____ (print name) hereby authorize Caplan Eye Clinic to use or release the following protected health information (Please specifically describe the information to be used or disclosed):

The protected health information may be (circle one): released to _____ requested from:
(Please insert name and address of person or entity)

Phone Number: _____

Fax Number: _____

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR (CHECK ONE)

At the patient's request (if the patient does not choose to provide an explanation)

Specific Purpose: _____

This authorization shall be in force and effect until _____ (date) or until the happening of the following expiration event _____ at which time this authorization to use or disclose this protected health information expires.

I understand that as set forth in the clinic's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Caplan Eye Clinic 3409 North Hullen Street Metairie, LA 70002.

I understand that revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that Caplan Eye Clinic will not condition my treatment on whether I provide the authorization for the requested use or disclosure. My signature is an acknowledgement that I have received a copy of this authorization.

Signature

Date

PRINT NAME

Relationship to Patient (if applicable)