West Eye Associates
555 Gettysburg Pike
Suite C-200
Mechanicsburg, PA 17055
(717) 796-2000 - Phone
(717) 796 - 2015 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ Date of Birth: _____
Organization Providing the Information: _____
Organization(s) or Person(s) Receiving the Information: **West Eye Associates**
Specific Description of Information Disclosed: **All Medical Records**

To the extent any of the following information is contained in my records being released, I specifically authorized the release of such information for the purposes indicated below by initialing before each category:

Initials: _____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;
Initials: _____ drug and /or alcohol diagnosis, treatment, test results and reports and referral information;
Initials: _____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
Initials: _____ venereal disease information;
Initials: _____ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure: **Per Patient Request**

You must read and initial the following statements:

1. I understand this Authorization will expire on ____/____/____(DD/MM/YR) or on the following event: Termination of the Physician/Patient Relationship. **Initials:** _____

2. I understand that I may revoke the Authorization at any time by notifying this Practice's Privacy Officer in writing, but if I do, it will not have any effect in any actions this practice too before they received the revocation. **Initials:** _____

_____ _____
Signature or Patient or Representative **Date**

_____
Relationship to Patient

You may refuse to sign this authorization. We cannot condition treatment on your signing this Authorization.