Authorization for the Use and Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____ **Ph:** _____

Request release of information FROM:
(Name and Address)

_____

_____

_____

Request release of information TO:
(Name and Address)

_____

_____

_____

Please select which records you are requesting *(check all that apply)* ☐ **Clinic Records** ☐ **Surgery Records**

Information to Be Used or Disclosed *(check all that apply)*
The information covered by this authorization includes:

- ☐ Any and all medical records (past year)
- ☐ Medical records from the following dates:
  From: _____ *To:* _____
- ☐ Diagnostic Testing
- ☐ Medical records relating to a specific injury
  Specify injury: _____
  Date of injury: _____

Purposes of Disclosure *(check all that apply)*
Information will be disclosed for the following purposes:

- ☐ Continuing medical/surgical care
- ☐ Insurance Company
- ☐ Attorney Request
- ☐ Personal
- ☐ Other (please specify)

_____

1. The person/organization authorized to use/disclose the information will receive compensation for doing so. ☐ Yes ☐ No
2. This authorization is effective through _____ unless revoked or terminated earlier by the patient or the patient's personal representative.
3. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage for services, or ability to obtain treatment. If the purpose of this authorization is for the use/disclosure of health information for a research study, and I refuse to sign this authorization, Edina Eye Clinic, P.A. & The Optical at 50th and France reserves the right to deny treatment associated with such research. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Edina Eye Clinic, P.A. & The Optical at 50th and France, reserves the right to deny that health care.
4. I understand that I may revoke this authorization at any time by notifying Edina Eye Clinic, P.A. & The Optical at 50th and France in writing except to the extent that: (1) action has been taken in reliance on this authorization; or (2) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. You should contact the Clinic Manager to terminate this authorization.
5. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
6. I understand that I may inspect or copy the information that is used or disclosed and that I have the right to request and receive a copy of the Notice of Privacy Practices from Edina Eye Clinic, P.A. & The Optical at 50th and France.

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Please return by one of these methods:

Address: 3939 W 50th St, Ste 200, Edina, MN 55424 | Fax: (952) 920-3225 | E: contact@edinaeyeclinic.com
For questions, please call us at: (952)920-2020