

Authorization for Release of Protected Health Information

Name of Patient: _____ Date of Birth: _____	
The office of Mandell Retina is authorized to release protected health information as described below for the identified patient.	
Entity to Receive Information. Check each person or class of persons that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Messages on _____ number.	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Other
<input type="checkbox"/> Spouse or Significant Other: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure)	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other: _____
Patient Rights: <ol style="list-style-type: none"> 1. I have the right to revoke this authorization at any time. 2. I may inspect or copy the protected health information to be disclosed as described in this document. 3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. 4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. 5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. 	
This authorization will remain in effect until I revoke it in writing. _____ Date _____	
Signature of Patient or Personal Representative *Description of Personal Representative's Authority (attach necessary documentation)	

