EYE CENTER
OF THE NORTH SHORE
EYE PHYSICIANS & SURGEONS

Patient Name_____ DOB_____

Phone number_____ Medical Records #_____

Address_____

☐ I hereby authorize Eye Center of the North Shore, LLC to disclose the following health information

To: _____.

☐ I hereby authorize_____ to disclose the following information to Eye Center of the North Shore.

1. **Specific Information to be released:**

☐ Medical records from this date_____ to this date_____.

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Comments: _____

_____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check in the box, Eye Center of the North Shore will release such information about me if it exists.

☐ HIV/AIDS infection ☐ Genetic information ☐ Sexually transmitted diseases ☐ Mental Health

☐ Treatment for drug and/or alcohol abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Eye Center of the North Shore. I understand that any previously disclosed information would not be subject to my revocation request.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

_____

_____

THIS FORM MUST BE FULLY COMPLETE BEFORE SIGNING

SIGNATURE of Patient of Legal Representative_____DATE _____

PRINT Patient Name _____

PRINT Name of Legal Representative (if applicable) _____Relationship to Patient_____