AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Information

Name: _____ DOB: ____ / ____ / _____

Address: _____

City / State / Zip: _____

I authorize the disclosure of my health information from:

Releasing Office: _____

Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

To be released to:

Bloomfield Eye Associates, PC

32255 Northwestern Hwy, Suite 45, Farmington Hills, MI 48334

Phone: 248-550-0393 **Fax:** 248-839-5909

Information to be released (check all that apply):

☐ Complete Medical Record

☐ Records from: _____ to _____

☐ Specific Dates: _____

☐ Other: _____

This authorization remains in effect until the information has been forwarded as requested.

Patient Rights:

- I may revoke this authorization at any time in writing, except where action has already been taken.
- Information disclosed may no longer be protected under HIPAA once released.
- I have the right to inspect or copy the disclosed health information.
- Refusal to sign this form will not affect my treatment.

Signature

Printed Name: _____

Signature: _____

Date: ____ / ____ / _____

If signed by personal representative, describe authority (attach documentation):

Office Use Only

Date Sent: ____ / ____ / _____ **By:** _____ **Via:** _____

Please retain a copy of this form for your records.