

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information:

Office Notes /Name of Physician Office. _____

Pathology Reports Radiology Reports Laboratory Reports Date(s): _____

Other: _____

The purpose for this request to release medical information is:

Medical Care / Treatment Insurance Other (specify) _____

Send my medical information to:

Novi Ophthalmology, PC

26850 Providence Parkway, Suite 240

Novi, MI 48374, Fax 888-443-3187

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Novi Ophthalmology, PC shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional NYSDOH HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- Novi Ophthalmology, PC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on ___ / ___ / ___ {if date not completed / one year after signed}

Patient / Representative Signature

Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

Print Name

Relationship to patient

Novi Ophthalmology, PC
37595 7 Mile Road, Suite 310
Livonia, MI 48152/ T(734)655-9010/ F(888) 443-3187

Retain this form in the patient's medical record and provide a copy to the patient.