Authorization for Release of Protected Health Information (PHI)

Patient Name _____ _____
Last First M.I. Previous or Other Names Used

Address _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth _____ **MRN #** _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose: _____

I authorize the release of records from:

_____

_____

_____

Please release requested medical records to:

Name: Attn: Medical Records Practice Name (if applicable) Glaucoma Institute of Austin

Address: 901 W 38th St Apt/Ste # 303

City: Austin State: Texas Zip Code: 78705

Telephone: (512) 452-8467 Fax Number: (512) 452-8440

I specifically authorize the use and disclosure of the following PHI
(Please provide a detailed description of the particular data and period of time for which you are requesting):

□ Clinic Records _____ □ Study Records _____

□ Fundus Photos / Slides _____ □ OCT _____

□ Surgery Records _____ □ Insurance Information _____

□ Visual Fields _____ □ Correspondence _____

□ Other _____

This authorization will expire on the 365th day after signing unless otherwise specified: _____.

By signing this Authorization Form, I understand that I am giving my authorization for GIA to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying GIA in writing to the Privacy Officer at 901 West 38th St. Ste 303, Austin, Texas 78705 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by GIA before GIA received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from GIA.

_____ _____
Signature of Patient or Authorized Personal Representative **Date**

_____
Relationship to the Patient (If signed by a Personal Representative)

GIA USE ONLY: Glaucoma Institute of Austin Original Medical Record Form | Revised June 2014

___ GIA to release PHI ___ Verify LAR
___ PHI already has been released; just file Authorization

Released: Date _____ Employee Initials _____
Method: ___ Mail ___ Fax ___ Secure Electronic Submission