OPTOMETRY **SERVICES**

Medical Records

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

338 West Tenth Avenue Columbus, OH 43210 Phone: (614) 292-2020 Fax: (614) 247-6626

Please print in Black or Blue Ink

A. Patient Name: _____ Date of Birth: _____

Last 4 of Social Security: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

B. I authorize The Ohio State University College of Optometry to:

☐ **Release medical information to:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

☐ **Receive information from:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

C. Purpose of disclosure: _____

D. Date(s) of Service and specific information to be disclosed:

☐ Exam summary ☐ Test Reports ☐ Prescription(s) ☐ Discharge Instructions

☐ Other (Specify) _____

E. This authorization will expire: ☐ 60 days from date of signature ☐ Other (specify) _____

F. Fees (OSU Optometry Services use only):

1. Prescription copies and copies of medical records sent directly to a physician or optometrist will be provided at no charge.
2. A per-page fee will be charged to the patient or patient's personal representative as follows:

First 10 pages	$3.07/page	Pages 11-50	$0.64/ page	For pages 51 and higher	$0.26/ page

3. A record search fee and per-page fee will be charged for requests made other than by the patient:

Initial Seach Fee		$18.93			
First 10 pages	$1.24/page	Pages 11-50	$0.64/ page	For pages 51 and higher	$0.26/ page

F. Statement of Understanding:

- I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization. Please refer to the Optometry Services Notice of Privacy Practices for additional information regarding revocation and disclosure of PHI;
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements;
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed;
- Optometry Services will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization;

X _____ _____

Signature of Patient or Person Authorized to Consent — Date Signed

X _____ _____

Printed Name — Relationship, if not the patient