OPTOMETRY **SERVICES**

Medical Records

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1664 Neil Avenue Columbus, OH 43201 Phone: (614) 292-2020 Fax: (614) 247-6626

Please print in Black or Blue Ink

A. Patient Name: ______________________ Date of Birth: ____________
Street Address: ______________________ Phone Number: ____________
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)
Other (Specify) ______________________________

E. 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

THE OHIO STATE UNIVERSITY
COLLEGE OF OPTOMETRY

Revised: January 2019
This form can be found at www.greatvision.osu.edu.