Ophthalmology & Oculoplastic Surgery, Inc.
150 Seventh Ave., Suite 100 Chardon, OH 44024
Phone: (440) 285-2020 Fax: (440) 285-8448

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Name: _____ Date of Birth: _____
Last First Middle Initial

Phone: _____ Last Four Digits of SSN: XXX-XX- _____

Authorization for Release of Protected Health Information (PHI): I voluntarily authorize and direct the physicians and staff of Opthalmology & Oculoplastic Surgery, Inc. (collectively "Kellis Eye Center") ☐ to release my PHI to ☐ to obtain my PHI from the recipient that I have identified below. **I understand that the information released/obtained may contain information concerning treatment for a psychiatric condition, a sexually transmitted disease, alcohol or drug treatment/abuse, HIV test results, an AIDS diagnosis or related condition and past medical history, and I expressly consent to such release.**
Recipient: Person or entity to whom Kellis Eye Center may disclose my health information:

Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

Purpose: ☐ Medical Care ☐ At the request of the patient ☐ Legal ☐ Other _____

Information to be released:
- ☐ Entire record of treatment provided by the physicians of Kellis Eye Center. ☐ Narrative Report ☐ Billing Records
- ☐ Only the following records: _____
- ☐ For following treatment date(s) _____.

Term: This Authorization will remain in effect for **ONE YEAR** if nothing is checked below.
- ☐ From the date of this Authorization until _____, 201_____.
- ☐ Until Kellis Eye Center fulfills this request. ☐ Until the following event occurs: _____

Redisclosure: I understand that once Kellis Eye Canter discloses my health information to the recipient identified above, Kellis Eye Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release Kellis Eye Center and its staff from any/all legal liability that may arise from the release of this information to the recipient named above.

Refusal to sign/right to revoke: **I understand that I may refuse to sign or may revoke this Authorization and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by Kellis Eye Center.**

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation at any time for any reason to Kellis Eye Center's Privacy Officer at the address listed below. The revocation will be effective immediately upon Kellis Eye Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I understand that I am entitled to a copy of this Authorization and that a copy of this Authorization is as valid as the original.

Questions: I may contact the Kellis Eye Center's Privacy Officer for answers to my questions about the privacy of my protected health information at 150 Seventh Avenue, Suite 100, Chardon, OH 44024, or by telephone at (440) 285-2020 Ext. 303.

_____ _____ _____
Signature of Patient/Legal Representative Date Signature of Witness for Legal Representative

If patient is unable to sign this Authorization, please complete the information below. If other than patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) MUST accompany this Authorization when presented. Exception: A parent signing for patient under age 18 who certifies there is no court order prohibiting parent from obtaining the requested records. If patient is deceased, executor/administrator appointment of patient's estate or nearest relative may sign.

_____ _____
Print Name of Legal Representative Legal Status/Relationship (e.g.: Parent/Guardian/Executor)

OFFICE USE: ☐ Hand Delivered ☐ Mailed ☐ Faxed ☐ Emailed Date: _____ By: _____