ADVANCED EYECARE
Robert Palozej, OD • Matthew Palozej, OD

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize Robert R. Palozej OD LLC to obtain **or** disclose:

□ my health information (DOB _____/____/_____)
□ my minor child/children's health information:
Child's name _____ DOB ____/____/_____
Child's name _____ DOB ____/____/_____
□ the health information of the patient for whom I am the authorized representative:
Patient's name_____ DOB ____/____/_____

as described below, to **or** from the following:

_____

Name Street Address City, State, ZIP Code

I request that the information to be used or disclosed consist of the following: (CHECK ALL THAT APPLY)

□ Complete Medical Record
□ X-ray Reports
□ Laboratory Reports
□ Hospital Records Including Reports
□ Prescription Data
□ Consultation Documentation
□ Surgical Reports
□ Summary of Record
□ Other (Specify):_____
□ I specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health may be used by or disclosed to the above referenced recipients.
□ I do not authorize the release of HIV/AIDS, substance abuse and/or mental health information.

It is my understanding that the information to be used or disclosed will be used for the following purposes (CHECK ALL THAT APPLY):

□ At the request of the individual signing this authorization
□ Additional Medical Care
□ Change of Provider
□ Insurance Eligibility/Benefits
□ Legal Investigation or Action
□ Other (Specify): ___

I understand that the disclosed information may be re-disclosed in accordance with law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand there may be a charge of up to $0.65 per page copied and for first class postage as generally allowable under Connecticut state law.

I understand that I am under no obligation to sign this form and that Robert R. Palozej OD, LLC. may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying Robert R. Palozej OD, LLC. in writing of my revocation. I am aware that my revocation will not be effective as to uses and/or disclosures of the health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE:
This Authorization is valid for one year from today's date or until _____. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Personal Representative Print Name and Relationship Date