Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the release of the following protected health information:

Name of Facility or Physician: _____

Office Notes Pathology Reports Radiology Reports Laboratory Reports Testing Date(s): _____

The purpose for this request to release medical information is:
Medical Care/Treatment Insurance Other (specify) _____

Send my medical information to:

Novi Ophthalmology, PC
26850 Providence Parkway, Suite 360
Novi, MI 48374
Phone 248-697-2822 Fax 888-443-3187

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Novi Ophthalmology, PC shall not be held liable for any consequences resulting from re- disclosure
- If the information to be released contains any information about HIV/AIDS an additional NYSDOH HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- Novi Ophthalmology, PC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on ___/___/___ (if date not completed / one year after signed)

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name Relationship to Patient