Eye Associates of Tallahassee

Authorization to Disclose Protected Health Information

The undersigned authorizes:

Eye Associates of Tallahassee
2020 Fleischmann Road
Tallahassee, FL 32308
Ph. 850-878-6161 ● Fax. 850-656-0200

to release my health information as noted below:

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ **Date of Birth:** _____

City: _____ State: _____ Zip: _____Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records.If so, an invoice will be provided to you through email or mail.

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax** #: _____

Purpose of Request: ___ Personal ___ Treatment ___Legal ___Insurance ___Transfer ___Other:_____

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

___Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**: _____:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

(**Please pick ONE delivery option**)

[ ] Send by Email **[ ] Records on CD**	**[ ] Fax to Doctor**	**[ ] Records on Paper**

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Florida State law Statute: 64B8-10.003.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____(*Please Initial*)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**_____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*