OPHTHALMIC PARTNERS
VISION•VISIONARY

Administrative Office:
100 Presidential Boulevard, Suite 200
Bala Cynwyd, PA 19004
Phone: (484) 434-2700 | Fax: (610) 660-0419
oppdoctors.com

Authorization for Ophthalmic Partners to Use or Disclose My Health Information

Patient Name: _____

Date of Birth: _____

I. My Authorization

You, Ophthalmic Partners, P.C., may use or disclose the following healthcare information:

- ❑ All my health information maintained by you
- ❑ My health information relating to the following treatment or condition: _____
- ❑ My health information for the date(s): _____
- ❑ Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please select one of the following:

❑ Mail Electronic Copy ❑ Patient Pick-up ❑ Authorized person picking up electronic record

❑ Encrypted Email to: _____ Name of Authorized Person: _____

Please note, unless otherwise specified, our office sends medical records in an electronic format on a CD. Additionally, we do not send records by email without written consent from the patient/patient's personal representative. Any records sent by email will be encrypted.

Reason(s) for this authorization (check all that apply):

- ❑ at my request
- ❑ other (please specify) _____

Additional comments: _____

_____

_____

CONTINUED ON NEXT PAGE

My Rights

- I understand that I have the right to revoke this Authorization at any time, except to the extent that Ophthalmic Partners has already acted in reliance on the Authorization.
- I understand that when Ophthalmic Partners discloses information about me, Ophthalmic Partners no longer directly controls the information. It is, therefore, possible that information disclosed under this Authorization could be disclosed by the recipient and no longer be subject to the protections provided by law.
- I understand that I do not have to sign this Authorization in order to receive treatment.
- I understand that by signing this Authorization, I am waiving any right to challenge the disclosure by Ophthalmic Partners under federal or state law.

Print Individual's Name **Date**

Signature of Individual or Individual's Personal Representative

If signed by a Personal Representative: my authority to sign this Authorization and agree to the terms herein exists because I am _____ (describe relationship to individual, or source of authority to sign on individual's behalf).

II. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this authorization can be released.**

- ❑ I consent to have the above information released.
- ❑ I do not consent to have the above information released.

Signature of Patient or legally authorized individual Date Printed Name

III. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.**

- ❑ I consent to have the above information released.
- ❑ I do not consent to have the above information released.

Signature of Patient or legally authorized individual Date Printed Name