## Patient Authorization To Release Protected Health Information

I authorize Oak Cliff Ophthalmology to release protected health information to the individual(s) listed below for the purpose of assisting with my care and/or payment.

|  |  |  |
| --- | --- | --- |
| Name | Relationship to Patient | Phone Number |
| Name | Relationship to Patient | Phone Number |
| Name | Relationship to Patient | Phone Number |

Description of the information to be used or disclosed:

* Patient’s demographic information
* Patient’s medical information
* Patient’s billing information

I understand that this authorization will be in effect during the time period that I am a patient at Oak Cliff Ophthalmology.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying *Oak Cliff Ophthalmology* in writing at *1114 North Bishop Ave., Dallas, Texas 75208.* I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

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Signature of Patient or Patient’s Representative Date

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Printed Name of Patient or Patient’s Representative Relationship to Patient or Legal Authority