Duplin Eye Associates

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information. I understand that this authorization is voluntary.

I understand that I may revoke or change this authorization at any time by giving written notice of my revocation to the contact office listed below, but it will not affect any information given prior to the revocation notice.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section A: Patient Information (please print):

Name:_____

Date of Birth:_____

Address:_____City_____State_____Zip Code_____

Telephone: ( ) _____-_____

Section B: Protected Health Information to be used and/or disclosed:

Yes☐ No☐ May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? Please list any individuals you wish to have this permission.

Name	**Relationship**
_____	_____
_____	_____
_____	_____

I give permission for the following medical information to be discussed:

CHOOSE ONE: ( ) All Medical Records

( ) Specific Records:_____

Expiration: This authorization will remain in place until a notice of change is provided in writing.

I acknowledge that I have received notice of the privacy practices of Duplin Eye Associates. I have had the opportunity to read and consider the contents of this notice.

_____ _____

Patient Signature Representative of Patient

_____ _____

Date Relationship to Patient

****Identification must be presented upon receipt of records.**

You can refuse to sign this authorization.

Office to Contact: Duplin Eye Associates, 304 N. Main Street, NC 28349