EVERGREEN EYE CARE

Authorization for Release of Health Information

Patient Name _____ Date of Birth _____

Patient Address _____ Patient Phone _____

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form be released. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to alcohol use, drug use, mental health, except psychotherapy notes, and HIV related information only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. This authorization does not authorize you to discuss my health information or medical care with anyone other than specified in item 9(b).

7. Name and address of health provider to release this information:

Felger Eye Care, PLC – DBA: Evergreen Eye Care. 17088 Robbins Rd., Grand Haven MI 49417

8. Name and address of person(s) to whom this information will be sent:

_____

9(a). Specific information to be released:

_____

"Entire Medical Record" means: patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

10. Reason for release _____

11. Date or event this authorization will expire* _____

**If no expiration date is listed, this authorization will automatically expire one year from the date below unless it is revoked by the individual in writing..*

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided with a copy of the form, if requested.

Date: _____ Signature of Patient or representative: _____

If not the patient, name of person signing form: _____

Relationship: _____

Updated: 5-20-24