Patients Authorization For The Release Of Protected Health Information

I, _____,DOB: _____authorize _____
(patient's name) *(date of birth)* *(doctor's office)*

to release my protected health information for a purpose I have stated below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to additional disclaimer by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be released *(check all that apply):*

- ☐ The patient's entire medical record including demographic information
- ☐ The patient's demographic information
- ☐ Medical Data/Information a related to:
  - ☐ Specific condition(s):_____
  - ☐ Specific professional service(s):_____
  - ☐ Specific medication(s): _____
  - ☐ Other medical data: _____
- ☐ Other:_____

The name and address of the person or medical facility you are authorizing the information to be released to:

The Eye Institute of Utah / The Surgicare Center of Utah

755 East 3900 South

Salt Lake City, UT 84107

Purpose(s) of the release of information:

_____

_____

This Authorization shall expire on _____. After this date the patient's protected health information can no longer be release without first obtaining a new authorization form. The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contest period. In order for revocation of this authorization to be effective, **The Eye Institute of Utah/The SurgiCare Center of Utah** must receive the revocation in writing. All revocations must be sent to the attention of the Administrator and are not effective until received by the Administrator.

I fully understand and accept the terms of this authorization and further understand this authorization is not a condition for treatment.

_____ _____

Patient Signature Date