Columbia Eye Clinic, PA

Columbia Eye Surgery Center, Inc

☐ **Clinic**-1920 Pickens St, Columbia, SC 29201 | ph: 803.779.3070 | fax: 803.771.7639
☐ **Surgery Center**-1920 Pickens St, Columbia, SC 29201 | ph: 803.254.7732 | fax: 803.748.7199
☐ 100 Palmetto Park Blvd, Lexington, SC 29072 | ph: 803.779.3070 | fax: 803.356.0668
☐ 100 Summit Centre Dr., Columbia, SC 29229 | ph: 803.779.3070 | fax: 803.256.8881

Authorization for Disclosure of Health Information

I, the undersigned, authorize Columbia Eye Clinic/Columbia Eye Surgery Center to release my health information as noted below:
Please return the **COMPLETED** authorization to one of the addresses noted above.
All sections must be completed for request to be processed.

PATIENT INFORMATION

Patient Full Name: _____ Other names during treatment? _____

Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____ Phone #: _____ Email: _____

Release information TO: (this section must be completed) **Mail _____ Fax _____ Pick up_____**

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED: (please specify the information to be released)

__ Entire Record __ Specific Date(s) of Service: _____

__ Specific Records (please list): _____

~Please check mark and initial each item below~

I __ **DO** __**DO NOT** want information about **Mental Health** released **Initial**_____
I __ **DO** __**DO NOT** want information about **HIV Tests & Related information** released **Initial**_____
I __ **DO** __**DO NOT** want information about **Alcohol and/or Substance abuse** released **Initial**_____
I __ **DO** __**DO NOT** want information about _____ released **Initial**_____

Release information FROM: (complete if requesting information from another entity that is not Columbia Eye Clinic/Surgery Center)

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Patient's Signature _____ Date _____
(Required for all patients 18 years and older)

Signature of Parent or Legal Guardian _____ Date _____
(Required for all patients under age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied.)

- This authorization will expire in 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the action the practice took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Columbia Eye Clinic/Surgery Center is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect the information that is used or disclosed.