CENTRAL FLORIDA EYE CARE, LLC
Authorization / Request for Release of Protected Health Information

Patient Information	I hereby authorize and request the disclosure of information from the health records of: Full Name_____ Phone _____ Address/City/State/Zip_____ Date Of Birth_____ SS#_____
Purpose	☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Worker's Compensation ☐ Personal/ Other
PHI to be Disclosed	☐ Consultation Report ☐ Operative Report ☐ Testing/Visual Fields ☐ Complete Record ☐ Other (Specify)_____
Release of Records <u>TO</u> Central Florida Eye Care.	☐ Release medical records to Central Florida Eye Care from: Name: _____ Address/City/State/Zip: _____ Fax No:_____
Release of Records <u>FROM</u> Central Florida Eye Care	☐ Release medical records from Central Florida Eye Care to: Name: _____ Address: _____ Fax No: _____ ☐ Mail or ☐ fax records directly to the person or organization specified above. ☐ Call me for pick up when records are ready. ☐ I authorize _____to pick up records for me. (Relationship to Patient):_____
Authorization	I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.
Signatures	• **My Signature is required to validate this authorization/ request.** _____ _____ **Signature of Patient / Guardian / Personal Representative** **Date** _____ _____ **Witness** **Date**

Fax this completed form
to Central Florida Eye Care
863-294-2334

Central Florida Eye Care Use Only:
Date Authorization/ Request Received:_____
Request Received by:_____
Date Request Completed:_____
Request Completed by:_____