# WEST COUNTY OPHTHALMOLOGY

**222 S. Woods Mill Road, Suite 660N**
**Chesterfield, MO 63017**
**Telephone: (314)878-9902**
**Facsimile: (314) 878-5112**

## AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIED HEALTH INFORMATION

**Patient name:** _____ **Record #:**_____ **Date of Birth**_____

I, or my personal representative, hereby authorize West County Ophthalmology to use or disclose protected health information regarding my care and treatment. I understand that:

**1.** Information relating to **ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT, GENETIC TESTING**, and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will not be disclosed unless I specifically authorize such disclosure by placing my initials in the appropriate space(s) in Item 8(b).

**2.** Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV-related information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV-related information without authorization.

**3.** I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent West County Ophthalmology has already relied upon this authorization.

**4.** Signing this authorization is voluntary. West County Ophthalmology may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

**5. Provider releasing this information** (one provider per form)**:**

Name: _____
Address: _____
_____

**6. Purpose for release of information:**
□ At my request □ Continuity of Care
□ Other: _____

**7. Person(s) receiving this information:**

□ Send to Name: _____

Address: _____

_____

□ I will pick it up

□ My personal representative _____ will pick it up.
(identification required for pick-up)

**8. Description of information being released:**

**(a) Specific date(s)** of service (required; list all dates):_____

_____

**I would like** (choose one)**:**

□ An abstract (pertinent information related to the above listed date(s))

□ My entire Medical Record

□ Other: _____

**(b) Include information relating to** (initial beside each applicable category):

□ **Alcohol/Drug Treatment** _____ □ **Mental Health Treatment** _____

□ **Genetic Testing Information** _____

□ **Psychotherapy Notes** _____ (If yes, complete a separate authorization form for this purpose)

□ **HIV-related Information** _____ (If yes, complete an official release form)

**9. Date or event on which this authorization will end:**

□ One-Time Request □ Specific Event or Date: _____

**10. Signature: By signing below I acknowledge that I have read and agree with all of the above.**

Signature:_____ Date: _____/_____/_____

Print name of patient or personal representative: _____

Personal representative's authority (supporting documentation required):

□Parent □ Guardian □Health Care Agent □ Administrator/Executor

□ Other: _____