LAKELAND OPHTHALMOLOGY

Parsippany NJ: 973.331.0300
Livingston NJ: 973.588.7005
www.eyedocnj.com

This Authorization form is Optional

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please fill in all shaded areas. Form must be signed and dated.

Patient Name: _____ **Date of Birth:** _____

Entity Requested to Release Information: _____ **Lakeland Ophthalmology** _____

Purpose of request (who will be authorized to receive information) - I authorize Lakeland Ophthalmology to disclose or provide protected health information, **about me to the individuals listed below.**

Who can we talk to?

Name: _____ Name: _____

Address: _____ Address: _____

Phone/Fax: _____ Phone/Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, only the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.