LAWRENCE EYE CARE ASSOCIATES, P.A.

Dr. Mary Pat Lange **Dr. Michael Mulhern**
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Lawrence Eye Care Associates, P.A. (LECA) is required to obtain your authorization for any use or disclosure of your protected healthcare information (PHI) for purposes OTHER THAN treatment, payment or healthcare operations. You have a right to review our Notice of Privacy Practices before signing this authorization.

Patient Name: _____ **DOB:** _____ **SSN:** _____-_____-_____

PHI Release To
Physician or Hospital Name: _____

Address: _____

Phone #: _____

Fax #: _____

Purposes of Disclosure
☐ Continuity of Care ☐ Personal Records ☐ Other: _____

Records to Be Released

☐ Physician Notes/H&P ☐ Operations/Procedures ☐ Special Testing ☐ Radiology ☐ Lab/Pathology	☐ I authorize the release of my complete health record, including records related to mental healthcare, HIV, AIDS and the treatment of drug or alcohol abuse. **OR** ☐ I authorize the release of my complete health record with the EXCEPTION of the following: ☐ HIV/AIDS ☐ Drug/Alcohol ☐ Other: _____

Expiration of Authorization is 90 days from the date it was signed unless otherwise written. _____

You May
- Request to inspect or copy the information that LECA intends to disclose
- Revoke this authorization in writing at any time by delivering a written revocation to Administration, Lawrence Eye Care Associates, P.A., except to the extent that LECA has already released information in reliance on this authorization.

LECA May
- NOT require that you sign this authorization to receive treatment
- Assess appropriate and reasonable fees for the copying of information. Such fees will comply with federal and state laws

I have read the above information and authorize Lawrence Eye Care Associates, P.A. to disclose the identified information to the person(s) and for purposes described herein. I understand that, by signing this document, I release and discharge Lawrence Eye Care Associates, P.A. from any and all liability and will hold Lawrence Eye Care Associates, P.A. harmless for any release made pursuant to this authorization. I understand that if the person or entity that receives the described information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.

Signature of Patient, Guardian or Authorized Rep: _____

Relationship: _____ Date: _____

Witness Signature: _____ Date: _____