HIPAA Release of Information
AUTHORIZATION FORM

Patient Name: _____ Date: _____

□ I hereby authorize Millican Eye Center to release my personal health information including diagnosis, treatment, claims payment, billing, and health care services provided or to be provided to me. This also includes identity information such as name, address, phone number, social security number and Member ID number.

□ Release of all information is authorized.

Information can be released to:

Name: _____ DOB: _____ Ph # _____

Name: _____ DOB: _____ Ph # _____

Name: _____ DOB: _____ Ph # _____

□ I do not want the following information disclosed to anyone:

_____

_____

□ Information is not to be released to anyone.

I understand this authorization is valid from the date of my/my representative's signature below and shall only expire or be revoked when Millican Eye Center receives WRITTEN NOTICE by me/my representative.

_____ _____ _____
Printed name of patient Signature Date

Legal Representative:
By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof, if requested, that I am legally authorized to act on the patient's behalf with respect to this authorization form.

_____ _____ _____
Printed name of legal guardian Signature Date