PROTECTIVE HEALTH INFORMATION RELEASE FORM

- Section I
  - Please complete all sections of this HIPAA Protective Health Information release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested. With signature below, I, give permission for Tozer Lee Eye Center to share the information listed in Section II of this document with the person(s) I have specified in Section III of this document

- Section II
  - Health Information I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

☐ Disclose my complete health record ***except*** for the following information:

☐ Billing records
☐ Mental health records
☐ Communicable diseases including, but not limited to, HIV and AIDS
☐ Alcohol/drug abuse treatment records
☐ Genetic information
☐ Other (Specify) _____

☐ I do not give anyone permission to access my PHI (Protected Health Information).

- Section III
  - I give authorization for the health information detailed in section II of this document to be shared with the following individual(s):

Contact 1
First and Last Name: _____
Date of Birth: _____ Relationship to Patient: _____
Contact Number: _____

Contact 2
First and Last Name: _____
Date of Birth: _____ Relationship to Patient: _____
Contact Number: _____

Contact 3
First and Last Name: _____
Date of Birth: _____ Relationship to Patient: _____
Contact Number: _____

I understand that the person(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

_____ _____
Patient or Legal Guardian Signature Date