Connecticut Eye Consultants, P.C.

Formerly Danbury Eye Physicians & Surgeons/Greater Waterbury Laser Eye Physicians

Phone (203) 791-2020 • Fax (203) 778-6238 • CTeye2020.com

69 Sand Pit Road Danbury, CT 06810 (203) 791-2020 phone (203) 778-6241 fax	120 Park Lane, Suite B203 New Milford, CT 06776 (860) 946-6000 phone (860) 799-6212 fax	166 Waterbury Road, Suite 201 Prospect, CT 06712 (203) 758-5733 phone (203) 758-7400 fax	1449 Old Waterbury Road, Suite 203 Southbury, CT 06488 (203) 264-4000 phone (203) 264-4002 fax	31 Porter Street Lakeville, CT 06039 (860) 435-0072 phone (860) 435-9831 fax

Authorization for Use or Disclosure of Protected Health Information

PATIENT'S NAME: _____ DATE OF BIRTH: _____PHONE: _____

FROM:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

FAX: _____

RELEASE TO:

NAME:_____

ADDRESS:_____

_____

PHONE:_____

FAX: _____

DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

☐ All medical records from _____ to _____
DATE DATE

☐ Specific information to be released as follows: _____

_____

_____

REASON FOR RELEASE: _____

A CHARGE OF $.65 PER PAGE FOR PERSONAL COPIES OF MEDICAL RECORDS PER CT STATUTE 20-7C

If records are being picked up in person by someone other than yourself, please state to whom you grant permission:

_____ _____
NAME RELATIONSHIP TO PATIENT

PHOTO ID IS REQUIRED TO PICK UP RECORDS

THE ABOVE MENTIONED PROTECTED HEALTH INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE PARTY RECEIVING THE INFORMATION AND MAY NO LONGER BE PROTECTED BY HIPAA PRIVACY RULES. BY SIGNING THIS FORM, YOU AUTHORIZE CONNECTICUT EYE CONSULTANTS, P.C. TO USE AND DISCLOSE PRIVATE HEALTH INFORMATION ABOUT YOU FOR THE REASONS STATED ABOVE. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR AUTHORIZATION. SUBMIT YOUR REVOCATION TO THE PRIVACY OFFICER OF THE PRACTICE. THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE UNLESS SPECIFIED.

I UNDERSTAND THAT THESE RECORDS MAY INCLUDE SENSITIVE INFORMATION ABOUT, HIV/AIDS, SUBSTANCE ABUSE, ALCOHOL ABUSE, MENTAL HEALTH, SEXUALLY TRANSMITTED DISEASES AND/OR ANY OTHER SENSITIVE INFORMATION.

If you have sensitive medical information that you DO NOT want disclosed, indicate it by initialing below:

_____ Substance abuse treatment information _____ HIV related information, including AIDS related testing

_____ Behavioral/psychiatric/mental health services _____ Sexually transmitted diseases

THIS AUTHORIZATION IS SIGNED BY: _____ _____
PATIENT/REPRESENTATIVE SIGNATURE DATE

_____ _____
RELATIONSHIP TO PATIENT DATE