PRISM Vision Group®

Authorization for Disclosure of Patient Medical Records

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Patient Last Name	First Name	Middle Name	Maiden Name	
Address (Street or Box)		City	State	Zip Code
Home Phone Number		Mobile Phone Number	Date of Birth	

Office use only (THIS PART MUST BE COMPLETED BY OFFICE STAFF):
Identity of Requestor verified via: ☐ Photo ID (on file) ☐ Other (Specify)_____
Patient Account Number_____
When medical records are disclosed, date disclosed, the recipient, and specific record(s) disclosed must be documented in the patient's medical record.

I, (print name) _____, am the above patient or Personal Representative of the patient. I give my permission for this PRISM Vision Group affiliated practice or ASC ("PRISM") to disclose the health information that I have specified below with the person(s) or organization(s) I have specified below.

- I understand that I have the right to revoke this authorization in writing by sending my request to revoke this authorization in writing to this office. In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. Please refer to the Notice of Privacy Practices for more on your right to revoke.
- I understand the information disclosed by this authorization may be subject to re-disclosure by the recipients and no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.
- I release **PRISM** its employees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- Disclaimer: **PRISM** will make every effort to include all requested information and records, but information may be inadvertently excluded on occasion. We apologize for any accidental omissions. If you are aware of any omission, please bring it to our attention.
- Service Charge: I understand that, as a courtesy to patients, **PRISM** offers one set of copies free of charge during the service period. If I request more than one set of copies of any or all of my records, during any 12-month period, I may be charged a fee according to applicable state law.
- I understand that PRISM may deny my request under limited circumstances as provided for under federal law. PRISM will notify you if it denies your request to access or obtain a copy of the requested information. If PRISM denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional.

Information to be released:
☐ Records from: (date of service) _____
to: (date of service) _____
☐ Chart Notes ☐ Images ☐ Complete Medical Record between the above dat
☐ Other (please specify) _____

Information that I do NOT want released:
☐ Alcohol / Drug ☐ Behavior / Mental Health / Psychiatric
☐ Sexually Transmitted Diseases ☐ HIV / AIDS
☐ Genetic Information ☐ No exclusions ☐ Other (Please Specify)

*Exclusions do not apply to Treatment, Payment, or Healthcare operations.

- I am requesting my information be released to (Name of recipient): _____
- If person is a Provider, please fill in this provider's phone number: _____
- I am requesting that my records to be delivered via the following delivery method (please check box): ☐Mail ☐Fax ☐Email ☐ Pick up at office
- Address of Recipient: _____
- Fax Number of Recipient: _____
- Email address of Recipient: _____
  *By checking the "Email box" and filling in email address above, I understand that my email may not be encrypted or secure and I understand that there may be risks in sending patient information by email.
- I would like to pick up my records at the office (please specify which office) _____
- Purpose for Release (please check applicable box or boxes):
  ☐ At request of patient ☐ Continuing Medical Care ☐ Worker's Comp ☐ Social Security
  ☐ Legal/ Litigation ☐ Disability Determination ☐ Insurance Claim ☐ Application for Insurance
  ☐ Other (Please Specify) _____
- This Authorization expires on the date or event written here: (enter date or event): _____

SIGNATURES

Patient Signature _____ Date _____
Legal Guardian/Personal Representative Signature (if applicable) _____ Date _____
If Personal Representative, what is your authority to act on behalf of the patient (e.g., Power of Attorney ("POA"), parent)? _____

Verbal Consent (if the patient is physically unable to provide a signature, office staff or another witness can sign on behalf of the patient):
I witness that the patient was physically unable to provide a signature, but that they understood the nature of this release and freely gave their oral authorization. Witness Name _____ Witness/ Signature_____ Witness Date_____
A patient may revoke authorization verbally if physically unable to provide a signature, if two witnesses sign here: _____
1) Witness Name _____ Witness Signature_____ Witness Date_____
2) Witness Name _____ Witness Signature_____ Witness Date_____