Hogan Eye Associates, Inc.
133 Loudon Rd., Suite 5, Concord, NH 03301
Phone: 603-224-3351 Fax: 603-225-7575

Donna M. Hogan, O.D.
Timothy J. Hogan, O.D.
www.hoganeye.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

NAME:				**DOB:**		
ADDRESS:		**PHONE 1:**		□ **HOME**	□ **MOBILE**	□ **OTHER**
CITY, STATE, ZIP:		**PHONE 2:**		□ **HOME**	□ **MOBILE**	□ **OTHER**

I authorize the release of protected health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

FROM:		**TO:**	
NAME:		**NAME:**	
ADDRESS:		**ADDRESS:**	
CITY, STATE, ZIP:		**CITY, STATE, ZIP:**	
PHONE:		**PHONE:**	
FAX:		**FAX:**	

1. Detailed description of the information to be released:

2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

3. Expiration date _____ or the event relating to the individual or purpose for the release:

It is completely your decision whether to sign this authorization form or not. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send the note to the office contact information listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility. (For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your protected health information in accordance with this authorization.)

□ I have read and understood this form. I am signing it voluntarily. I authorize the disclosure of my protected health information as described in this form.

SIGNATURE:		**DATE:**	

(PATIENT, PARENT/GUARDIAN, OR AUTHORIZED REPRESENTATIVE)