McCONNELL
EYE ASSOCIATES

Stephen McConnell, MD
American Board of Ophthalmology, diplomate

HIPAA AUTHORIZATION FORM

I authorize **McConnell Eye Associates, LLC** to obtain, use and disclose my protected health information (PHI) listed below for the purpose listed elsewhere on the page.

- ❑ Medical records including office visits, lab results, operative notes
- ❑ Radiology reports and films

My protected health information may be discussed with and disclosed to the following non-medical persons:

_____ _____

_____ _____

Please mark any restrictions on release of PHI to the persons listed above

- ❑ Office visit
- ❑ Surgery
- ❑ Medication management and release of prescription

Date that this authorization will end (if any specific date or event shall end: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to McConnell Eye's Privacy Office at (2712 Parkwood Drive; Brunswick, GA 31520). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect renumeration to the physician from a third party.

X _____ Date: _____

Signature of Patient

2712 Parkwood Drive
Brunswick, GA 31520

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