Canyon Eye Associates

Authorization for Use or Disclosure of Health Information

Name:_____DOB:_____ SS# *XXX-XX-*_____

I hereby consent to and authorize, _____, to release, use or disclose the following health information relating to my care:

☐ All records pertaining to current and past medical history, mental or physical, diagnostic and lab testing, test results, and any treatment received by me.

☐ Only the following records:

_____

_____

_____

The information will be used or disclosed for the following purpose(s):

☐ To assist in services, care, and treatment of the patient.

☐ At the request of the patient.

Records should be sent to:

☐ Canyon Eye Associates Fax # (614) 866-6964

☐ _____ Phone# _____ Fax# _____

_____ _____

Print Name *Date*

_____

Signature

You have the right to revoke this authorization by doing so in writing. Revocation of the authorization will be effective if action has not been taken, or if the authorization was obtained as a condition for obtaining insurance coverage, and only to the extent the law provides the insurer with the right to contest a claim under the policy

The information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect the individual health information from use or disclosure by health care providers.

JENNIFER YOUNG, M.D. ● AARON MACK, M.D. ● LAURIE RAHARDJANOTO, O.D.
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