HIPAA Release Form

Patient Information

I, _____ (DOB: _____),
allow **Precision Eye Institute** to share my health information as listed below.

Health Information to Share

(Check one)
☐ Share my complete health record, including diagnoses, test results, treatments, and billing.

OR
Share my record, except for:
☐ Mental health records
☐ Communicable diseases (HIV/AIDS, etc.)
☐ Alcohol/drug treatment
☐ Genetic information
☐ Other: _____

Format of Disclosure:
☐ Electronic copy ☐ Hard copy

Reason for Sharing

(Write the reason, or if you do not wish to list the reasons for sharing, write “At my request.”):

Who Can Receive My Information

Name of Organization: _____

Phone/Address:

_____

_____

Family/Friend:

Name: _____ **Relationship:** _____

Phone: _____

How Long This Permission Lasts

(Check one)
☐ From _____ to _____
☐ All past, present, and future records
☐ Until this event: _____

I understand I can cancel this permission anytime in writing.

Signature

Patient Signature: _____ **Date:** _____

Printed Name: _____

(If signing for someone else)

Guardian/Representative Name: _____

Signature: _____

Relationship: _____