Columbia Eye Clinic, PA

Columbia Eye Surgery Center, Inc

☐ **Clinic**-1920 Pickens St, Columbia, SC 29201 | ph: 803.779.3070 | fax: 803.771.7639
☐ **Surgery Center**-1920 Pickens St, Columbia, SC 29201 | ph: 803.254.7732 | fax: 803.748.7199
☐ 100 Palmetto Park Blvd, Lexington, SC 29072 | ph: 803.779.3070 | fax: 803.356.0668
☐ 100 Summit Centre Dr., Columbia, SC 29229 | ph: 803.779.3070 | fax: 803.256.8881

☐ 3227 Sunset Blvd, Suite C, West Columbia, SC 29169 | ph: 803.779.3070 | fax: 803.926.1178

Authorization for Disclosure of Health Information

I, the undersigned, authorize Columbia Eye Clinic/Columbia Eye Surgery Center to release my health information as noted below:
Please return the **COMPLETED** authorization to one of the addresses noted above.

All sections must be completed for request to be processed.

PATIENT INFORMATION

Patient Full Name: ____ Other names during treatment? ____________________

Address: ____ City: ______________________ State: ____ Zip: _______

Date of Birth: _____________ Phone #: __________________ Email: ____

Send my information TO: (this section must be completed) **Mail ______** **Fax ______** **Pick up______**

Name/Facility: ____ Attention: _____________________________

Address: ____ City: ______________________ State: ____ Zip: _______

Phone: _______________ Fax: ________________

INFORMATION TO BE RELEASED: (please specify the information to be released)

__ Entire Record

__ Specific Date(s) of Service: ____________________________

__ Specific Records (please list): ____

~Please check mark and initial each item below~

I __ **DO** __**DO NOT** want information about **Mental Health** released **Initial**_______
I __ **DO** __**DO NOT** want information about **HIV Tests & Related information** released **Initial**_______
I __ **DO** __**DO NOT** want information about **Alcohol and/or Substance abuse** released **Initial**_______
I __ **DO** __**DO NOT** want information about _______________________ released **Initial**_______

Release my information FROM: (complete if requesting information from another entity that is not Columbia Eye Clinic/Surgery Center)

Name/Facility: ____ Attention: _____________________________

Address: ____ City: ______________________ State: ____ Zip: _______

Phone: _______________ Fax: ________________ ***PLEASE MAIL IF OVER 50 PAGES**

Patient's Signature ____ Date _________
(Required for all patients 18 years and older)

Signature of Parent or Legal Guardian _______________________________________ Date ___________
(Required for all patients under age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied.)

- This authorization will expire in 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the action the practice took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Columbia Eye Clinic/Surgery Center is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect the information that is used or disclosed.

Revised 8/2022