WOOSTER EYE CENTER

(Wooster Ophthalmologists, Inc., Eye Surgery Center of Wooster)
3519 Friendsville Rd., Wooster, OH 44691
Phone: (330) 345-7200 ❖ (Fax: 330-345-8029)

MEDICAL RECORDS RELEASE

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

PATIENT NAME: ______________________________ **DOB:** ______________

1. I hereby authorize the use or disclosure of my health information as described below.

Release of info. ❒ from (or) ❒ to:	❖	**Release of info. ❒ from (or) ❒ to:**
Wooster Eye Center Eye Surgery Center of Wooster 3519 Friendsville Rd. Wooster, OH 44691		______________________________ ______________________________ ______________________________

2. Specific description of information to be released (check applicable choices):

❒ My entire medical office chart ❒ My entire chart from the surgery center
❒ My medical office records from dates: ____________ to ____________(specific dates)
❒ My health information relating to (diagnosis, injury, etc.): ______________________
❒ Other (explain): ____

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3. The information will be released for the purpose of:

❒ At the request of the patient/ individual (if individual chooses not to specify purpose)
❒ For an employment purpose (specify): ______________________________
❒ For an insurance purpose (specify)______________________________
❒ For other purpose: ______________________________________

4. Expiration Date or Event: This authorization will expire on ___/___/___ or on the occurrence of the following event: ______________________, or 60 days from date signed, if no expiration date shown.

5. I understand that I have the right to revoke this authorization at any time by completing a revocation form available from Wooster Eye Center. If I revoke this authorization, I understand it will not have any effect on information released before the revocation took effect. I also understand that this authorization is voluntary and that Wooster Eye Center may not condition treatment on my signing this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that a fax copy or photocopy of this authorization shall be as valid as the original.

Signed: X______________________________ **Date:**____________________

(If signed by personal representative, describe authority to sign: ______________________)

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