CLARITY
EYE AND FACE

DOB Phone Number MRN

Patient HIPAA Authorization for Release of Protected Health Information

I authorize the use or disclosure of the following Protected Health Information as described below

☐ Records relating to treatment from the following dates: _____ to _____

☐ Records for all care at this facility

☐ Records for all care at this facility by Dr. _____

☐ Other (please specify): _____

Information to be released

☐ From ☐ To	☐ From ☐ To Clarity Eye and Face, PLLC
Address	Address One Town Square Blvd, Ste 218 Asheville, NC 28803
Phone	Phone (828) 333-4844
Fax	Fax (828) 585-7621

I would like to receive my records via: ☐ Fax ☐ Mail* ☐ In person* ☐ Email:

I understand that this authorization will expire 90 days from the date it is signed. I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, Clarity Eye and Face must receive the revocation in writing. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that a copy of this authorization is valid as an original.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal privacy standards. I further understand that Clarity Eye and Face may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization. Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements.

By signing below, I acknowledge that I have read, understand and accept the terms of this authorization

_____ _____
Signature of Patient (or person authorized to sign) Date

Self
Relationship to Patient

***Fee schedule:** State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee to copy records is $0.75 per page for the first 25 pages, $0.50 per page for additional pages up to 100, and $0.25 for each additional page in excess of 100. No fee shall be charged for reproducing and forwarding records directly to other physicians

Note: Please allow a minimum of 2-4 weeks for records to be transmitted