COHN EYE CENTER

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Diplomate American Board of Ophthalmology
Diseases and Surgery of the Eye
Glaucoma Specialist

## Authorization for Use and Disclosure of Protected Health Information

The HIPAA privacy rules provide important protection for health information including that your authorization is obtained in certain circumstances. The HIPAA privacy rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Please release all my medical records (including visual fields, operative reports, diagnostic images, and other pertinent medical information) to the following individual/entity:

| FROM or TO: (circle one) | FROM or TO: (circle one) |
|---|---|
| *THE COHN EYE CENTER* | _____ |
| | _____ |
| | _____ |
| | _____ |

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV, sexually transmitted diseases, psychiatric or mental health disorders, and/or drug or alcohol use. If I have been tested, diagnosed, or treated for HIV, sexually transmitted diseases, psychiatric or mental health disorders, and/or drug or alcohol use, I am authorizing you to release all healthcare information pertaining to such diagnoses, testing or treatment.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

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