HARBOR
EYECARE CENTER

164 EPPING ROAD
EXETER, NH 03833
PHONE: 603-430-0211
FAX: 866-694-2132

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. PATIENT INFORMATION (Please Print Clearly):

NAME: _____ DOB: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

B. I AUTHORIZE HARBOR EYECARE CENTER TO **RELEASE/RECEIVE** (Please Circle One) MEDICAL INFORMATION **TO/FROM** (Please Circle One):

NAME: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

OFFICE PHONE: _____ FAX: _____

C. STATEMENT OF UNDERSTANDING:

- ❖ I may revoke this authorization at any time in writing to the provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.
- ❖ Federal regulations will no longer apply to the information disclosed, and that the provider receiving this information may re-disclose the information.
- ❖ I am entitled to receive a copy of this authorization.
- ❖ A copy of the authorization may be utilized with the same effectiveness as an original.
- ❖ This authorization is valid for 365 days from date signed.

PATIENT OR REPRESENTATIVE SIGNATURE:

_____

PATIENT OR REPRESENTATIVE PRINTED:

_____

RELATIONSHIP TO PATIENT:

_____

DATE: _____