THE EYE INSTITUTE OF WEST FLORIDA
1225 West Bay Drive | Largo, FL 33770
(727) 581-8706
www.eyespecialist.com

EYE PHYSICIANS OF PINELLAS, P.A.

HIPAA Authorization For Use Or Disclosure Of Protected Health Information (PHI)

Patient Name _____ Guardian or Authorized Party Name (if applicable) _____

Date of Birth _____

I authorize the use and disclosure of my health information as described below:

Information Requested:

_____ Records relating to treatment dates from: _____ to: _____

_____ Records for all care at this facility or by this doctor

_____ Other (please specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where used or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date. 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.

Information to be released ☐ from ☐ to The Eye Institute of West Florida (Fax: 727-450-3062)

Information to be released ☐ from ☐ to Name: _____

Address: _____

Phone: _____ Fax: _____

_____ (Initials of patient or guardian) I understand that The Eye Institute of West Florida may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient or Guardian** _____ Date _____

A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions I DO_____ DO NOT_____ authorize the release of this information.

****If this authorization is signed by an individual's personal representative, the representative's authority is based on: (e.g. state law, court order, etc.)**

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The flat fee for reproducing medical records is $6.50.

For Office Use Only:

Physician Authorization: _____ Date Sent: _____ By: _____

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INFORMATION REGARDING MEDICAL RECORD REQUESTS

We will ask that you sign an authorization to release medical records, in accordance with our Notice of Privacy Practices.

In accordance with the standards set by HIPAA, we respectfully request that you allow us 30 days to process your record release request. If your record is stored off site, we request up to 60 days to process your requests. In most cases, we will more than likely be able to complete your request in less time, generally 7 – 10 business days.

Note that under the Health Insurance Portability and Accountability Act (HIPAA) a covered entity can only charge "reasonable" cost-based fees for providing the medical records to patients. See 45 CFR 164.524(c). We have opted to charge a flat fee of $6.50.

There is NO CHARGE for a patient whose records are copied if it is necessary for the continuation of medical care. This can be demonstrated by having the records sent directly (via USPS or fax) to the treating physician or facility.

We reserve the right to withhold the requested information until payment of the reasonable fee is received as stated in our Notice of Privacy Practices.

Please email your completed medical records request to med.records@eyespecialist.com