The Eye Associates of Michigan

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Patient Name: _____ _____ ____ DOB: _____
First Last MI

Address: _____ _____ _____ _____
City State Zip

I hearby authorize the release of my health information from:

Doctor/Practice: _____

Address: _____ _____ _____ _____
City State Zip

Contact: _____ _____ _____
Phone Fax Email

I hearby authorize the release of my health information to:

The Eye Associates of Michigan
My Le Shaw, MD Evan Field, MD
14272 Fenton RD Fenton, MI 48430
Phone: 810 - 777- 8326 Fax: 810 -777- 8327 Email: team@myeyeteam.com

Information to be released:

- ☐ Complete Medical Record
- ☐ Medical Records for specific dates of service From: _____ To: _____
- ☐ Other (Please List): _____

This authorization will remain in effect until the information has been forwarded as requested

Purpose of Disclosure: Continuation/Coordination of Care

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above.
I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the the recipient and may no longer be protected by federal or state law.
Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA).
I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Printed Name of Patient or Patient Representative | Signature of Patient or Patient Representative | Date

_____
Description of Representative's Authority (attach legal documentation)

For Office Use Only: INCOMING RECORDS
Date Sent: _____ Via: _____ By: _____