

# Muirfield Eye Care

6105 Memorial Drive Dublin, OH 43017 Phone (614) 793-8440 Fax (614) 793-8383  
www.muirfieldeyecare.com

---

## AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
SSN: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

---

I authorize Muirfield Eye Care Center to:

Release medical information to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Request medical information from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Please select all the specific documents that apply to your request:

Exam Summary       Test Reports       Prescription(s)       Other (specify)

---

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

---

Signature of Patient, Parent, Guardian, or Representative

Date

---

Print Name