



The Eye Center, PA
 1655 Bernardin Avenue Suite 100 Columbia, SC 29204
 Phone 803-256-0641 Fax 803-779-3649

Consent to give access of Medical Records (Protected Health Information). Please print all information. Form must be signed and dated each year.

Patient Name: _____ Date of Birth: _____ SSN(last 4 digits): _____

Entity Requested to Release Information: **The Eye Center, P.A.**

Purpose of request – I authorize **The Eye Center, P.A.** to give access to my medical records to the person(s) listed below:

Name: _____ Phone: _____

Relationship: Spouse / Father / Mother / Son / Daughter / Other: _____

Description of Information to be disclosed – I authorize the following to be disclosed by **The Eye Center, P.A.**:

- Entire patient record; **or**, check **only** those items of the record to be disclosed.
- Office notes
- Lab results, pathology reports, and/or CT/MRI results
- Financial history report (previous 3 years)
- Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

- Patient Request
- Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

 Patient or representative signature

 Date

You have the right to receive a copy of signed authorizations upon request.