

Talley Eye Institute

Authorization for Release / Request of Protected Health Information (PHI)

Patient Name _____ Date of Birth _____

Address: _____
Street City St Zip

Phone Number _____

Please select one:

_____ I authorize Talley Eye Institute to **obtain** information from:

OR _____ I authorize Talley Eye Institute to **release** information to:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone # / Fax # (Include Area Code)

Phone # / Fax # (Include Area Code)

What information can be disclosed? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box:

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Office Exams | <input type="checkbox"/> Financial Assignment |
| <input type="checkbox"/> Diagnostic Tests | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Referral Information |
| <input type="checkbox"/> Other _____ | | | |

REASON FOR DISCLOSURE (Choose only one option):

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Transfer | <input type="checkbox"/> Treatment/Continued Patient Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Billing or Claims |
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Insurance | <input type="checkbox"/> School | <input type="checkbox"/> Other _____ |

Enter the dates for these records: All dates From: _____ To: _____

Effective Time Period: This authorization is valid for **one time use only**, per the date signed below.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described.

Signature of Individual or Legal Authorized Representative Date

Relationship of Legal Authorized Representative to Individual: Parent Guardian Other _____

In accordance with state law and regulatory agency requirements, the health record is the property of Talley Medical Surgical Associates, PC. HIPAA and Indiana Code 16-39-1-4 require a signed authorization from the individual or legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law.

Talley Eye Institute cannot attest for the accuracy of any part of the medical record that is redisclosed from an entity other than Talley Eye Institute and its members, nor can Talley Eye Institute answer any questions about said record

Prepayment Charge: There is a prepayment charge of \$15 per record.