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:

☐ **All health information** ☐ History and Physical ☐ Office Exams ☐ Financial Assignment

☐ Diagnostic Tests ☐ Face Sheet ☐ Lab Reports ☐ Referral Information

☐ Other _____

REASON FOR DISCLOSURE (Choose only one option):

☐ Transfer ☐ Treatment/Continued Patient Care ☐ Personal Use ☐ Billing or Claims

☐ Attorney/Legal ☐ Insurance ☐ School ☐ 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.

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

******Please mail charts that are over 25 pages in length. Do not fax them. Thank you.******

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