WillsEye Hospital

RELEASE OF INFORMATION AUTHORIZATION

FAX NUMBER 215-825-9086

Patient Name:_____ Birth Date:_____

_____

Full Address: Street/City/State/Zip

_____ _____ _____

Telephone Number Social Security Number **(last 4 digits only)** Medical Record Number

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Disclosed Information

Please specify the information to be released (the exact information and format must be specified, e.g., verbal discussion, written reports, photographs, etc. and the dates or range of dates of treatment requested, if applicable

_____

_____

I understand that information in response to this request may be related to testing of AIDS/HIV, whether the result is negative or positive, treatment for drug and alcohol use/abuse, and psychiatric care or treatment.

AIDS/HIV Information: Please initial here: _____Yes, Disclose _____ No, do not disclose
Drug or Alcohol use/abuse: Please initial here: _____Yes, Disclose _____ No, do not disclose
Psychiatric Care/Treatment: Please initial here: _____Yes, Disclose _____ No, do not disclose

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Information Provided To

_____

Name of Person/Institution and Full Address Telephone Number

_____

Full Address: Street/City/State/Zip

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Purpose of the Requested Information

This information is requested for the purpose of_____

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Authorization Expires

This authorization Expires (insert date, event, or condition) _____ If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

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Authorization

I hereby authorize Wills Eye Hospital and its controlled affiliates, including Wills Eye Ophthalmology Clinic, Inc., (collectively, "Wills") to disclose the health information described above.

I understand that I may revoke this authorization at any time by written request made to the Privacy Officer at Wills Eye, 840 Walnut Street, Philadelphia, PA 19107, except to the extent that action has been taken in reliance on this authorization. My refusal to sign this form will not affect my treatment, except when I have requested a service by Wills and the purpose of the service is to provide health information to a third party at my request. It is possible that information disclosed under this authorization might be disclosed by the recipient and no longer be protected. This form has been fully explained and I certify that I understand its contents.

Patient Signature_____ Date_____

Signature of Person Authorized in Lieu of Patient_____

Relationship to Patient_____

Witnessed by_____ Date_____

Records of deceased patients: If the requestor is not the executor of the decedents' estate then the requestor certifies by signing above that he/she is the next of kin responsible for the disposition of the decedent's remains.