John L. Mason, OD

MASON family vision

Katherine S. Mason, OD

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORD RELEASE

Federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Most health insurers, pharmacies, doctors and other health care providers are required to comply with these federal standards.

PATIENT NAME: _____ DOB: ____/____/____
Last *First*

☐ AT MY REQUEST, I AUTHORIZE:

Name: _____
Address: _____
Phone: _____
Fax: _____

☐ AT MY REQUEST, I AUTHORIZE:

Mason Family Vision
141 Wildewood Park Drive
Columbia, SC 29223
Phone: 803-865-5520
Fax: 803-865-5496

TO DISCLOSE THE FOLLOWING INFORMATION:

☐ any and all of the medical records pertaining to the treatment of the individual

☐ other _____

☐ TO MAKE THE DISCLOSURE TO:

Mason Family Vision
141 Wildewood Park Drive
Columbia, SC 29223
Phone: 803-865-5520
Fax: 803-865-5496

☐ TO MAKE THE DISCLOSURE TO:

Name: _____
Address: _____
Phone: _____
Fax: _____

I understand the nature of this release. I understand that I am not required to sign this form. I also understand that if the person or organization I authorize to receive the information is not subject to federal health information privacy laws, that person or entity may further disclose the protected health information and federal privacy laws may no longer protect it.

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing. Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below. I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ ____/____/____
Signature of patient / legal guardian *Relationship to patient / legal authority* *Date*