1135 W University Dr, Suite 155
Rochester, MI 48307
Phone: 248-710-2325
Fax: 248-266-8293

MICHIGAN Ophthalmology

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

SS Number (Last 4 digits only): XXX-XX-_____ **Date of Birth:** _____

I, _____hereby authorize _____, its Director or Designee, or Health Information Management /Medical Records Department, to release protected health information to:

MICHIGAN OPHTHALMOLOGY
1135 W. UNIVERSITY #155
ROCHESTER, MI 48307
Email to records@mieyedoc.com or fax 248-266-8293

I understand that my protected health information disclosed to Michigan Ophthalmology under this Authorization will continue to be protected by HIPAA privacy laws.

Requested Information to be disclosed:

- **Previous 3 ophthalmology office visits chart notes**
- **Previous ophthalmology surgical notes**

Previous ophthalmology testing/imaging:

- **All Visual Field Testing. (If applicable)**
- **All Optical Coherence Tomography (OCT) imaging. (If applicable)**
- **All Fundus Photography imaging. (If applicable)**

This authorization can be revoked, in writing, at any time except to the extent that the information has already been released or disclosed. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.

This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

_____ _____

Signature of Patient or Legal Representative Date