Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group
9002 N. Meridian St, #100 · Indianapolis, IN 46260
Phone: (317) 844-5530 · Fax: (317) 844-5590

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

____ ________________
Name of Patient/Previous Names Birth Date

________________________________ ________________________________
Street Address City, State, Zip Code

AUTHORIZES:
❒ Price Vision Group ❒ Other:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

____
Phone Fax

TO RELEASE HEALTH INFORMATION TO: ✱
❒ Price Vision Group ❒ Other:

____
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

____
Phone Fax

INFORMATION TO BE RELEASED:

❒ **ENTIRE RECORD** ❒ History, Phys. Exam, Reports ❒ Operative reports ❒ Laboratory Reports
❒ All ophthalmic testing ❒ Consultations ❒ Imaging Reports ❒ Billing Records
❒ Other (Specify): ____

For the Following Date(s): ____

PURPOSE FOR DISCLOSURE:

____

✱ I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

RIGHTS WITH RESPECT TO THIS AUTHORIZATON:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Officer. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION: This authorization is good until ______/______/______ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and agree to pay any applicable fees.

PATIENT SIGNATURE: ______________________________ **DATE:** ________________
(If signed by other than patient, state relationship and authority to do so.)

Rev 1-21-16