

**AUTHORIZATION FOR USE/DISCLOSURE  
OF HEALTH INFORMATION**

**Authorization for Use/Disclosure of Information:** I voluntarily consent to an authorize my health care provider - Gettysburg Ophthalmology Associates - to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my health care information to be released to the following recipient(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Purpose:** I authorize the release of my health information for the following specific purpose:

\_\_\_\_\_  
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

**Information to be disclosed:** I authorize the release of the following health information:  
(check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- Only the following records or types of health information:

\_\_\_\_\_.

**Term:** I understand that this Authorization will remain in effect:

- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.
- Until the Provider fulfills this request.
- Until the following event occurs: \_\_\_\_\_.
- Redisclosure:** I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Gettysburg Ophthalmology Associates. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Gettysburg Ophthalmology Associates at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact Helen Reed, Office Manager for answers to my questions about the privacy of my health information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
Name of Guardian/  
Representative

\_\_\_\_\_  
Legal Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

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