Palm Beach Eye Clinic
130 Butler St, West Palm Beach, FL 33407
(561) 832-6113 PHONE
(888) 366-1852 FAX

AUTHORIZATION FOR RELEASE OF YOUR HEALTH INFORMATION

Patient name: _____ **Date of birth:** _____

Phone #: _____ **SS #: XXX-XX-**__ __ __ __

I authorize Palm Beach Eye Clinic to use or disclose my health information as described below to the following individuals or entities:

- ☐ **MYSELF**
- ☐ **OTHER (list name and addresses below)**

_____
_____
_____

RELEASE CONTENT: Dates of Service: _____

☐ Face Sheet	☐ Allergies	☐ Other _____
☐ Visit Notes	☐ Medication Information	☐ Past Medical History
☐ Insurance Information	☐ Billing Record	☐ All Information

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REASON FOR DISCLOSURE: My health information is being released or disclosed for the following reasons:

☐ Personal	☐ Research and Research Oversight
☐ Further medical care	☐ Changing Physicians
☐ Legal Investigation or Action	☐ Other _____
☐ Insurance Eligibility/Benefits	

I understand that this authorization is voluntary. If I do not sign this form, my health care by Palm Beach Eye Clinic will not be affected. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.

_____ _____ _____
Signature of patient or patient's representative **Date** **Print Name of Patient**
(Do not sign until the information above is filled in completely.)

If Authorized Representative signs form, please check reason:
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased Legal Authority ☐ Custodial Parent
☐ Legal Guardian ☐ Executor of Estate Deceased ☐ Power of Attorney ☐ Authorized Legal Representative