Patient Authorization for Release Protected Health Information

By signing this authorization, I authorize __________________________to disclose certain Protected Health Information (PHI) about me to Center for Eye Health, Inc. to the party/or parties listed below:

HERBERT S. RUBIN, M.D./JOSEPH J. LEVY, M.D./PAUL E. BEADE, M.D., SEAN P. THOMAS, M.D./JOHN P. DONAHUE, M.D.

This authorization permits ____________________________to disclose to CENTER FOR EYE HEALTH, INC., the following individually identifiable heath information about me including, but not limited to, origin of information, diagnoses, treatment, test results, dates of service, previous medical history.

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The information will be used or disclosed for the following purpose ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

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This authorization will expire at the patient's request, or six (6) years from date of signing. I do not have to sign this authorization in order to receive treatment from Center for Eye Health. In fact, I have the right to refuse to sign this authorization. I have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to review this authorization in writing except to the extent that the Center for Eye Health, Inc. has acted in reliance upon this authorization. My written revocation must be subjected to Center for Eye Health's Privacy Officer at Truesdale Clinic, 1030 President Avenue, Fall River, MA 02720.

Signed by: ________________________________ ____________________
Signature of patient or legal guardian Relationship to patient

____ ____________________
Patient's Name Date

____ ____________________
Home Address Date of Birth

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PLEASE SEND RECORDS TO:
1030 PRESIDENT AVENUE
FALL RIVER, MA 02720

CENTER FOR EYE HEALTH, INC.
ONE PEARL STREET, SUITE 1100
BROCKTON, MA 02301

THIS IS A TWO (2) PAGE DOCUMENT, PLEASE TURN THE SHEET OVER.

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing below, I specifically authorize the use/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization.

(Note to patient: Please circle any bullet points listed below to the extent you <u>DO NOT WANT</u> the information disclosed by the practice).

- Information about HIV/AIDS status
- Information about genetic testing
- Information related to confidential communications with psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence or other allied mental health professionals or human services professional
- Information about treatment of substance abuse (alcohol or drug)
- Information about venereal disease(s)
- Abortion consent form(s)
- Mammography records
- Information about family planning services
- If I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- Information related to mental health community program records
- Information about research involving controlled substances

________________________________	________________________
Signature of Patient	**Date**

If the patient is an un-emancipated minor or otherwise incapacitated (physically or mentally) obtain the following signatures:

________________________________	________________________	__________
Signature of Personal Representative	**Description of Authority**	**Date**