



338 West Tenth Avenue  
Columbus, OH 43210  
Phone: (614) 292-2020  
Fax: (614) 247-6626

### AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print in Black or Blue Ink

A. Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

B. I authorize The Ohio State University Optometry Services to **release/receive** (Please circle one) Medical Information **to/from**:  
Name: \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Information May Be (Please check one):  Mailed to the recipient in Section B  Picked up by recipient in Section B  
 Faxed to the recipient listed in Section B  Received by Optometry Services

C. Date(s) of Service & Reason for Request:  
D. Information Being Requested:  History and Physical  Test Data/Lab Reports  Test Data/Lab Reports  
 Prescription(s)  Discharge Instructions  Other (Specify) \_\_\_\_\_

F. Fees (OSU Optometry Services use only):  
1. Prescription copies will be provided at no charge.  
2. A record search fee and/or a per-page fee may be charged. Please contact the Medical Records Department at (614) 247-6190 for additional information.

F. Statement of Understanding:  
▶ I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization. Please refer to the Optometry Services Notice of Privacy Practices for additional information regarding revocation and disclosure of PHI;  
▶ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements;  
▶ I understand and acknowledge that this authorization extends to use and/or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed;  
▶ Optometry Services will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization;  
▶ This authorization is valid for 60 days, unless otherwise revoked by my written notice.

I hereby authorize The Ohio State University Optometry Services and its employees to release/receive the information requested in Section D above. I expressly consent to the transfer of information to the designee listed in Section B above.

X \_\_\_\_\_  
Signature of Patient or Person Authorized to Consent Date Signed

X \_\_\_\_\_  
Printed Name Relationship, if not the patient