Stokes Regional Eye Centers
Sumter Eye Center

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Stokes Eye Center/Sumter Eye Center (SREC/SEC) is authorized to release protected health information (PHI) on the above named patient in the following manner and to the identified persons listed below.

Disclosures to Authorized Individuals
I authorize SREC/SEC to release my PHI and/or billing information to the person(s) listed below.

_____

Name Relationship Date of Birth Phone Number

Health Information: ☐ Yes ☐ No **Financial Information**: ☐Yes ☐ No

_____

Name Relationship Date of Birth Phone Number

Health Information: ☐ Yes ☐ No **Financial Information**: ☐Yes ☐ No

OR

_____ (initial) I do not wish to designate a representative to receive any of my protected heath information.

Contact Information
I authorize SREC/SEC to communicate my protected health information in the following manner (please check all that apply):

☐ Home phone: _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell phone: _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Work phone: _____ ☐ Detailed Message ☐ Call Back Message Only

I understand that if I have checked the box "detailed message," I agree that SEC may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked in writing by the patient.

_____ _____

Signature of Patient **OR** *Patient Representative/Relationship Date

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jun 2017