6140 S Memorial Dr
Tulsa, Ok 74133
Phone: 918-252-2020 Fax: 918-252-7466

Patient Name: ______________________________ DOB: ____________________

I hereby authorize: ________________________________ To use and/or disclose

the protected Health Information describe below to: ________________________________

For the Purpose(s) of

____

P.H.I. (Specific information to be released: Notes, Reports, Films, etc.)

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1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

2. I understand that Triad Eye Institute will not condition treatment, payment or (if Applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the privacy officer of Triad Eye Institute. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance

4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Expiration date or event: This authorization will expire on (date no later than one year from now)

Date: ________________________
(If no date is stated, this authorization expires six months from the date it was signed.)

Patient Signature or Legal Representative: ____________________ Date: ____________