Patient Authorization to Release Personal Health Information

Southern Vitreoretinal Associates, P.L.
2439 Care Drive
Tallahassee, FL 32308
(850) 942-6700
(850) 942-5735 FAX

I hereby authorize Southern Vitreoretinal Associates, P.L. ("**Practice**"):

(i) to furnish reports and records relating to my examination or treatment to Authorized Recipient;
(ii) to discuss my medical condition with Authorized Recipient; and
(iii) to otherwise disclose to Authorized Recipient protected health information concerning me; *provided that* such protected health information is directly relevant to Authorized Recipient's involvement with my care or payment related to my care.

For purposes of this Authorization, the term "**Authorized Recipient**" means:

(i) any family member, other relative, or close personal friend of mine;
(ii) any person accompanying me to Practice's facility or other facility at which Practice is treating me;
(iii) any person calling from, or answering the telephone at, my residence who advises Practice that he or she is involved in my care or payment related to my care; and
(iv) any other person that I identify (in writing, orally or otherwise) as a person authorized to receive protected health information concerning me, including without limitation the person(s) listed on the attached Exhibit "A" Authorized Recipients.

This Authorization shall remain in effect from the date signed below until cancelled in writing or the following expiration date or event:_____.

I understand that:

- This Authorization is for my benefit and convenience, and is for the purpose of enhancing my care. This Authorization shall not limit any use or disclosure of protected health information permitted under applicable law.
- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this Authorization in writing by contacting Practice's office at the address above, attention Privacy Officer. I may refer to Practice's *Notice of Privacy Practices* for additional information concerning my right to revoke this Authorization.
- Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 164, Subpart E. Florida Statutes Section 456.057(10) provides, however, that a third party to whom information is disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.
- I may refuse to sign this Authorization and that Practice will not condition treatment or payment on my providing this Authorization (except to the extent that the authorization is for research-related treatment, in which case Practice may refuse to provide that research-related treatment).
- I have a right to receive a copy of this Authorization upon request.
- Medical records maintained by Practice may contain records from other health care providers.

I hereby release and agree to hold harmless Practice, and its directors, officers, shareholders, employees, and agents, from all liability, including for negligence that may arise from complying with this Authorization.

Patient Name: _____

Signature: _____

Relationship to Patient (if signed by personal representative of Patient): _____

Date: _____

OVER →

Exhibit A
Authorized Recipients

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