Practice: Winthrop Eye Center

Family/Friends Disclosure Authorization

I, _____, give permission to all my health care services providers to disclose and release my protected health information described below to:

Name(s):	Relation:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

____ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

____ My complete health record, as above, with the *exception* of the following information:

- ____ Mental health records
- ____ Communicable diseases (including HIV and AIDS)
- ____ Alcohol/drug abuse treatment
- ____ Other (please specify): _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall be effective until (Check one):

____ All past, present, and future periods OR

____ Date or event: _____

You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.

_____

Name of the individual giving this authorization

_____ _____

Signature of the individual giving this authorization Date