Release of Personal Health Information Form and Policy

Monarch Eye Care will release medical information to individual patients based on the following policy in accordance with local state and federal regulations regarding the release of protected medical information: Upon request and completion of this form, a copy of a patient's current valid eyeglass or contact lens prescription will be provided to the patient by email, fax, or in person at no charge to the patient, provided such prescription is not expired and all fees for requested records are paid in full. Upon request and completion of this form, a copy of a patient's medical record will be provided at any time at a clerical charge of $25.00 plus $0.65 per page for the first 30 pages and $0.50 for any additional pages. Medical records will only be copied and released for requested dates. Copies of medical records can be picked up at 1101 N Main St Suite 304 Summerville, SC 29483, mailed (postage & handling + sales tax for mailing fee is 12.50), or faxed. Email such as gmail is not a secure method to transfer records and is highly discouraged. Patients or their legally-authorized representative must provide valid photo identification when copies of the records are requested. Legal guardianship for adults or conservatorship will need documented proof for release of records. Copies of medical records will be provided within 30 days of submitting this signed request.

I, ____, hereby voluntarily authorize the disclosure of information from my medical record.

The information is to be disclosed by:
Monarch Eye Care

And provided to: ____

The purpose or need for this disclosure is for:

____

The information to be disclosed from my health record is:

☐ Valid Glasses Prescription or Contact Lens Prescription

☐ Examination Records for selected date(s): __________________
____

☐ Entire Medical Record

I understand that I may revoke this authorization in writing at any time. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by

the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 522a].

____ ____________________

Signature (if under 18: parent/guardian signature, Date

Patient Identification: Full Name:

____

Patient Date of Birth: __________________________________

Patient Social Security Number: ________________________________

Current Address for Mailing: ____

Fax for Records: ___________________________________

Contact Phone for credit card payment: _________________________________, or mail a check to Monarch Eye Care. 1101 N Main St Suite 304, Summerville SC 29483.

Full Name of Legal Guardian or Conservator: __________________________________

Signature of Legal Guardian or Conservator: ___________________________________

Date of Birth: ______________________________

1101 N. Main St. Suite 304
Summerville, SC 29483
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