NECO | Center for Eye Care
New England College of Optometry

Authorization for Use and Release of Health Information

Patient name _____ Date of Birth_____

Address_____

Patient Phone Number _____ Today's Date_____

I authorize the New England College of Optometry Center for Eye Care and New England College of Optometry Clinical Network (together referred to as "New England College of Optometry") to disclose or request my protected health information to the person or class of persons listed below.

Enter where you would like information sent from, and to whom you would like the information sent to.

FROM (e.g. hospital, clinic, or provider name):	**TO:** (e.g. To whom you would like the information sent)
Name	Name
Address	Address
Phone	Phone
PURPOSE: (Check the appropriate box) * Copying fees may apply ☐ Medical Care ☐ Personal ☐ Insurance* ☐ School ☐ Legal Matters* ☐ Other _____	**SEND BY:** ☐ Paper Copy via Mail ☐ Secure E-Mail (**must sign E-Mail consent form**), e-mail address _____ ☐ Fax # _____

Types of Medical Records requested

☐ Notes from most recent eye examination	☐ Entire clinical record < 3 examinations (free)
☐ Most recent contact lens fitting examination/prescription	☐ Entire clinical record > 3 examinations ($15 fee to patient)
☐ All eye care exam notes within the last 12 months	☐ Other: _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

☐ Alcohol/Drug Abuse Treatment	☐ HIV/AIDS Diagnosis and/or Treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release as required by M.G. L.c.III, § 70F.
☐ Sexually Transmitted Diseases	
☐ Details of Domestic Violence Victim's Counseling	
☐ Details of Sexual Assault Victim's Counseling	
☐ Communication between Patient and Social Worker	☐ Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic genetic tests). Initial Here to specifically authorize its release as required by M.G. L.c.III, § 70G.
☐ Details of Mental Health Diagnosis/Treatment provided by Licensed Mental Health Clinician	

Authorization Agreement

☐ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.

☐ This authorization is voluntary

☐ **I understand that there is a $15 charge if a request of an entire record (re cords outside of 1 year) are made.**

☐ I decline the opportunity to inspect or copy the information released.

☐ My questions about this authorization form have been answered.

☐ I understand that I may revoke this authorization at any time by notifying New England College of Optometry Center for Eye Care/New England Eye in writing and that if I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.

☐ I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.

☐ This authorization will expire 12 months from fulfillment of the request unless I specify a different expiration date/event here _____.

_____ _____

Signature of Patient or Personal Representative | Relationship if signed by Personal Rep.

_____ _____

Print Name | Date

Mail or fax to: NECO Center for Eye Care, 930 Commonwealth Ave, Boston, MA 02215, fax 617-236-6323

Mail or fax to: NECO Center for Eye Care, 4199 Washington St. #2, Roslindale, MA 02131, fax 617-553-2121