JERVEY EYEGROUP
Our Mission: Your Best Vision

Jervey Eye Group
601 Halton Road Greenville, SC 29607
(P): 864-458-7956 (F): 864-458-3895

Release of Information Authorization

Patient Name:_____ Date of Birth: _____

Last 4 Digits of SSN:_____ Phone Number: _____

I authorize Jervey Eye Group, PA to (circle one) disclose / retrieve my health information to / from:

Name of individual/healthcare provider/practice/hospital: _____

Address:_____ City:_____

State:_____ Zip Code:_____ Phone#:_____ Fax#: _____

Please (circle one) FAX / MAIL

☐ All of my health information

☐ My most recent eye exam

☐ My health information from__/__to__/__

☐ Other _____

For the purpose of:

☐ Continuing Care
☐ Patient Request
☐ Transfer of Care
☐ Legal Action
☐ Insurance/ Disability Coverage
☐ Other _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original. This authorization will expire/end one year from the date of signature unless otherwise specified.

I understand this medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, abortion, sexually transmitted disease, HIV testing and/or AIDS diagnosis or treatment, or mental health treatment. By signing below you consent to having the above information released.

Printed Name of Patient or Legal Guardian/Representative: _____

Relationship to Patient, if Signed by Legal Guardian: _____

Signature of Patient:_____ Date:_____