Wooster Eye Center
3519 Friendsville Rd
Wooster, Ohio 44691
Phone: 330-345-7200, Toll Free: 1-800-442-4599

HIPAA – Medical Records Release / Authorization for use or disclosure of information

Form 7.34

Patient Name:_____ DOB:_____ Phone:_____

Address:_____ _____ _____ _____
(Street) (City) (State) (Zip code)

1. I hereby authorize the use or disclosure of my health information as described below

Release of information ☐ from (or) ☐ to:	❖	Release of information ☐ from (or) ☐ to:
Wooster Eye Center	|	_____
3519 Friendsville Rd	|	_____
Wooster, Ohio 44691	|	_____

2. Description of information to be released (check applicable choices):

☐ My medical chart from these specific dates: _____ to _____
☐ My entire medical chart ☐ My entire chart from the surgery center
☐ My health information relating to a condition or injury - explain_____
_____
☐ Other purpose (explain):_____

3. The information will be released for the purpose of:

☐ At the request of the patient/individual (if individual chooses not to specify purpose)
☐ For transfer of care to another provider
☐ For an employment purpose (specify):_____
☐ For an insurance purpose (specify): _____
☐ Other purpose:_____

4. Expiration Date or Event:
This authorization will expire on ____/____/____ or on the occurrence of the following event:
_____, or 60 days from the date signed, if no expiration date is shown.

5. I understand that I have the right to revoke this authorization at any time in person by completing a revocation form available from Wooster Eye Center or, by mailing a written request to the practice, Attn: Privacy Manager. If I revoke this authorization, I understand it will not have any effect on information released before the revocation took effect. I also understand that this authorization is voluntary and that Wooster Eye Center may not condition treatment on my signing this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that a faxed, electronically sent, printed or photocopy of this authorization shall be as valid as the original.

Signed: X_____ Date: _____

(If signed by personal representative, describe authority to sign):_____