AUTHORIZATION

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.
555 S. 18TH ST. 4-C
Columbus, Ohio 43205
614-224-6222
614-241-5232 fax

Authorization to Access or Release Protected Health Information

Indicate purpose: ___ Review of/access to Medical record ___ Request to release copies to third party

I hereby authorize **Pediatric Ophthalmology Associates, Inc.** to disclose the following personal health information about me as instructed below.

______________________________ ______________________________
PATIENT'S NAME **DATE OF BIRTH**

____
ADDRESS

____

1. **Description of Records to be Released/Disclosed:**

____

____

2. **Name(s) of Individuals or Entities to Which Record(s) Should be Disclosed:**

____
NAME **PHONE** **FAX**

____
ADDRESS

____

3. **The purpose of the authorized use or disclosure described above is as follows:**

___ Transfer of Records to New Treatment Provider
___ Insurance Review or Dispute
___ Attorney Review
___ School Examination
___ Personal Use
___ Other (be specific) ______________________________________

Other Information:

1. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

2. As described in the Notice of Privacy Practices of Pediatric Ophthalmology Associates, Inc., I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Pediatric Ophthalmology Associates, Inc. in reliance on this authorization, by sending a written revocation to Pediatric Ophthalmology Associates, Inc. 555 S. 18th St. 4-C Columbus, OH 43205, Attn: Privacy Officer.

3. This authorization will automatically expire in **60 days, per the state of Ohio Release of Medical Information Rule,** unless an applicable date or event is entered which **does not exceed the 60 day rule.**

* Insert applicable date or specific event: ______________________________________

4. I understand that I am not required to sign this authorization form and that Pediatric Ophthalmology Associates, Inc. will not condition the provision of treatment or payment to me on the signing of this authorization except that Pediatric Ophthalmology Associates, Inc. may condition the provision of research related treatment to me on the signing of this authorization for the use or disclosure of personal health information for such research. Pediatric Ophthalmology Associates, Inc. may also condition the provision of health care that is solely for the purpose for creating protected health information for disclosure to a third party on the signing of this authorization.

5. I understand that Pediatric Ophthalmology Associates, Inc. is permitted by law to deny part of or all of my request for access to one of more of the following reasons:

- My access request form is not signed by me (the patient) or my representative;
- My access request for is signed by my representative and my representative has not provided information on the source of his/her authority to act on my behalf;
- Pediatric Ophthalmology Associates, Inc. does not maintain the information that I have requested to copy or inspect;
- The information that I have requested is not a part of our records;
- My request is for psychotherapy notes;
- My request includes information compiled for litigation;
- My request includes information created or obtained in the course of research still in progress that includes my treatment and I agreed to this denial of access when consenting to participate in research;
- A licensed health professional has determined that the requested access is likely to either endanger me or another person's safety or cause substantial harm to me or another person;
- My request is to copy information and I am an inmate of a correctional facility (I retain the right to inspect information); or
- My request relates to certain information that was obtained from a confidential source and Pediatric Ophthalmology Associates, Inc. is not required to provide access to it by law.

6. I understand that in this authorization includes the use and/or disclosure of information from the patient medical or financial records as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AID related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

7. I understand that I may be required to pay fees in advance for any copies requested. The fee schedule as determined by Ohio law is as follows:

Patient:		**Other/Facility:**	
	$ No search fee		$16.84 Initial search fee
	$ 2.74 per page for pages 1-10		$ 1.11 per page for pages 1-10
	$ .57 per page for pages 11-50		$ .57 per page for pages 11-50
	$ .23 per page for pages 50+		$ .23 per page for pages 51 (+)
	Actual Postage		Actual Postage

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Name of Personal Representative, If Applicable

____

Relationship of Personal Representative to the Patient

____

Signature of Patient (or Personal Representative) **Date**

____

Name of Pediatric Ophthalmology Associates Representative **Date**

(To be signed by office personnel)