Palmetto Eyecare Associates, P.A.

2460 India Hook Road, Suite 206
Rock Hill, SC 29732
Tel: 803-985-2020

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Patient making Request), DOB _____
hereby authorize the below party to use and disclose:

- o My entire medical record
- o Portions of my Medical Record, specifically: _____
- o Date Specific Portions of my Medical Record, From: _____ to _____

_____ (hereafter referred to as the "Practice")

_____

_____

Phone: _____

Fax: _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed below. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, it employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of super-confidential information as stated in the NOPP:

- o HIV records (including HIV test results) and sexually transmissible disease
- o Alcohol and substance abuse diagnosis and treatment records
- o Psychotherapy records
- **X** **Not Applicable**

In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____
2. Please Release my records to: **Palmetto Eyecare Associates, P.A.** (Name of Medical Professional or Third Party)
3. The Records will be obtained by:

X Send Third Party a copy of my records to :

(OR) **2460 India Hook Road, Suite 206**
Rock Hill, SC 29732

X Fax a copy of my records to this fax number: **(803) 985-2021**

_____ _____
Patient or Patient Representative Signature Date

_____
Patient or Patient Representative Printed Name