Champlain Ophthalmology
James M. Heltzer, M.D.
Omar R. Chaudhary, M.D.
Alexander Baten-Tschan, M.D.
Aspen Chun, O.D.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

____
Patient Name (Please Print)

____
Guardian or Authorized Party Name

____
Date of Birth

I authorize the use and disclosure of my health information as described below:

Records relating to treatment dates from: ____________ to: __________

Records for all care at this facility, or by Doctor______________________

I give my healthcare provider permission to discuss protected health information with _______________________(Name of Individual)

Information to be released:

from to

____
Name

____
Address

____

____
Phone

____
Fax

from to

<u>Capital Eye Care, LLC.</u>
Champlain Ophthalmology

6720A Rockledge Drive Suite 200
Bethesda, MD 20817
T: 301-493-9600 F: 301-493-9235

Form in which records are to be released:

- ☐ Paper Copies
- ☐ Flash Drive ($35 upfront charge)
- ☐ Mail
- ☐ Fax
- ☐ Pick up

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage. I understand that uses and disclosures already made based upon my original permission cannot be taken back. **I understand that the medical records to be released may contain information related to HIV status, AIDS, Sexually Transmitted Diseases, alcohol, or mental health services, and I hereby authorize the release of the information.** To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in a year from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproducing and forwarding of medical records. Black and White copies of last 4 visits free, if more is necessary, a preparation fee of $22.88, plus $0.76 per page, plus postage will be charged.

I understand that Capital Eye Care, LLC, Champlain Ophthalmology may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

____
Signature of Patient or Guardian

____
Date

A fax copy or photocopy of this consent shall be as valid as original. If this authorization is signed by a patient's personal representative, the representative authority is based on __________________________.
(Parent, Law, Court order, POA, etc.)

For office use only:
Physician Authorization: ______________________ Date Sent: ____________ By: ____________________