Cleveland Sight Center

Authorization for the Release and Disclosure of Protected Health Information

Client name:	Date of birth:
Name of the parent or guardian:	Telephone number:

I hereby authorize and request the release and disclosure of my individually identifiable health information as described below.

☐ To ☐ From	Cleveland Sight Center ☐ Fax: _____ ☐ Mail to: CSC Records Attn: _____ 1909 East 101st Cleveland, OH 44106
☐ To ☐ From	_____ (Name) _____ (Address) (City/State) (Zip) _____ (Phone Number) (Fax Number)
Purpose for disclosure:	☐ At the client's request ☐ Other _____
Dates of service:	From _____ to _____

☐ Treatment plan ☐ Medical Records ☐ Discharge summary
☐ Eye report ☐ Assessment reports ☐ Educational records (ETR/IEP)
☐ Observations ☐ Therapy (OT, PT, SLP) ☐ Progress notes

☐ Other _____

Signature of client, parent, or personal representative*:	Date signed:
Printed name:	
Relationship, if not client:	

*If other than client's signature, a copy of legal documents verifying client's personal representative MUST accompany this request (e.g., court appointed guardian, durable power of attorney for health care). Exception: Parent signing for a client under the age of eighteen.

Understandings and Agreements of Requestor:

1. I understand that if the person or entity receiving the Protected Health Information described above is not a service/health care provider or a health plan covered by federal privacy laws, the health information to be disclosed, as described above, may no longer be protected by these laws and may be used without limitation (subject to other applicable laws) or may be re-disclosed to non-covered entities.
2. I understand I may revoke this authorization at any time by notifying Cleveland Sight Center in writing, but that if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____ (if I do not specify, this authorization will expire two years from the date it is signed).
3. I understand that Cleveland Sight Center and its employees are released from any legal responsibility or liability for disclosure of my Protected Health Information as described above and as authorized by my signature.
4. I understand that I have the right to inspect or copy any of the information disclosed by this authorization.