EASTWEST
EYE INSTITUTE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize ___________________ to release information from the record of ______________________________
Name of Facility / Person Patient Name
_______________: __________________ as described below to ____
Birth Date SSN / MR # Name of Facility / Person
Phone:____________________________ Fax: _______________________________

Records are requested for the purpose of **(PROVIDE A DETAILED DESCRIPTION):**

The records to be released (identify all that apply) are **(please include approximate dates of service):**
___ Inpatient Records; Dates _____________ ; _____________ Emergency Room Records, Dates__________________
___Outpatient Records; Dates _____________ ; _____________ Physician Office / Clinic; Dates ____________________

- Medical History & Physical Exam
- Disability Summary/Instructions
- Pathology
- Consults
- Physician Orders
- Progress Notes
- Laboratory Reports/Tests
- Medication Records
- Radiology
- Mammography Report
- Psychiatric/Psychological Eval
- Operative Report
- Other (specify): ___________________ ________________________________

HIV, Behavioral Health and Drug and alcohol information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated. Do not release [ ] HIV [ ] Behavioral Health (Psychiatric) [ ] Drug & Alcohol

I understand the following:

- That my health record(s) will not be released or obtained by EWEI unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by EWEI may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) EWEI and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule
- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific timeframe is documented, however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to ____at the following
(facility / person)
Address: ____
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization form.

LOS ANGELES
420 E. 3rd Street, Ste. 603
Los Angeles, CA 90013
Telephone (213) 680-1551
FAX (213) 680-2148

GARDENA
1045 W. Redondo Beach Blvd., Ste. 400
Gardena, CA 90247
Telephone (310) 329-9975
FAX (310) 329-4759

TORRANCE
23441 Madison Street, Ste. 120
Torrance, CA 90505
Telephone (310) 373-6708
FAX (310) 378-6395

PASADENA
50 Alessandro Pl., Ste. 150
Pasadena, CA 91105
Telephone (626) 389-1310
FAX (626) 389-1311

WEST LOS ANGELES
1950 Sawtelle Blvd., Ste. 240
Los Angeles, CA 90025
Telephone (310) 453-0489
FAX (310) 453-0886

EASTWEST
EYE INSTITUTE

GENERAL AUTHORIZATION

____ ________________________
Patient Signature Date

The above named patient is unable to provide a signature due to:

____

____ ________________________
Legal Representative Signature Date

Relationship to Patient AND Description of authority to act on behalf of patient:

____

ORAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witnessed that the person understood the nature of this release and freely gave his/her oral authorization.
(Two Witnesses are required.)

____ ________________________
Witness #1 Date

____ ________________________
Witness #2 Date

- A minor may authorize if for Drug and Alcohol related; If for Behavioral Health, a patient who is 14 or older shall authorize (inpatient records only) A disclosure statement, as required by law, will accompany the records requested.

Office Use Only [ ] Copy provided to patient Signature:________________________________

LOS ANGELES
420 E. 3rd Street, Ste. 603
Los Angeles, CA 90013
Telephone (213) 680-1551
FAX (213) 680-2148

GARDENA
1045 W. Redondo Beach Blvd., Ste. 400
Gardena, CA 90247
Telephone (310) 329-9975
FAX (310) 329-4759

TORRANCE
23441 Madison Street, Ste. 120
Torrance, CA 90505
Telephone (310) 373-6708
FAX (310) 378-6395

PASADENA
50 Alessandro Pl., Ste. 150
Pasadena, CA 91105
Telephone (626) 389-1310
FAX (626) 389-1311

WEST LOS ANGELES
1950 Sawtelle Blvd., Ste. 240
Los Angeles, CA 90025
Telephone (310) 453-0489
FAX (310) 453-0886