

**Columbia Eye Clinic, P.A.**  
**Columbia Eye Surgery Center, Inc.**

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100 Palmetto Park Blvd.  
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(803) 806-0080  
Fax: (803) 356-0668

100 Summit Centre Dr.  
Columbia, SC 29229  
(803) 252-8566  
Fax: (803) 256-8881

**Authorization for Release of Protected Health Information**

Patient's full name at the time of treatment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

I authorize the release of the following records (specify): \_\_\_\_\_

Entity Providing Information:

Person or Entity Receiving Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail Records

I will Pick-Up Records

Fax Records to:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable disease, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3. I understand that I may revoke this authorization at any time, but the revocation will not apply to the information that has already been released. Revocations should be sent to any address noted at the top of this form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information.
6. I understand that this authorization will expire 90 days after the dated signed unless specified otherwise.

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

**PROVIDER USE ONLY:**

Date Records Sent: \_\_\_\_\_ Copy to: \_\_\_\_\_