JEA
JACKSON EYE ASSOCIATES
Your Vision, Our Mission.℠

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

JEA ACCOUNT #	PATIENT NAME	DOB
PATIENT ADDRESS		

Release From / Release To	JACKSON EYE ASSOCIATES 1200 N STATE ST STE 330 JACKSON MS 39202-2027 *Healthcare Facilities may contact for direct messaging address	601-353-2020 OFFICE 601-352-5988 FAX
Release From / Release To		
Purpose and Date Range		
Expiration Date or Event		If you provide no expiration date or event, release expires one year from date of signature.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that as with any disclosure of information, federal confidentiality rules may not protect the potential for an unauthorized re-disclosure. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

RECORDS CHARGE: $20.00 for pages 0 – 20. $1.00/page for pages 21+.

I have read the preceding Authorization for Release of Information and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature & Date	
Printed Name	
Relation to Patient	

Revised 07/2017