SOUTHEASTERN
OCULARISTS, INC.
Custom Made Ocular Prosthetics

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize __________________________ to use or disclose my Protected Health
(Eye Doctor/Primary Care Doctor)
Information as described below: I understand that the information I authorize a person/facility may be redisclosed and no longer protected by state and federal regulations.

Patient Name: ____ DOB: _________________
Address: ____
Social Security Number: _____________________ Phone Number: _____________________

Name of Doctor/facility authorized to RELEASE the information: _________________________
(Eye Doctor/Primary Care Doctor)

Name of Person/facility authorized to RECEIVE the information:
Southeastern Ocularists, Inc
8426 Medical Plaza Dr, Suite 500, Charlotte, NC 28262
P: 704-510-9292 F: 704-510-9881 E: seocularists@gmail.com

Purpose of Disclosure: <u>To obtain prior authorization and for use as proof of medical necessity with regards to the patient's insurance only.</u>

Information to be Used/Disclosed:

□ Complete Records □ History & Physical □ Progress Notes
□ Laboratory Reports □ Pathology Reports □ Operative Reports
□ Hospital Reports

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing, except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

________________________________ ______________________
Printed Name of the Patient Date

____
Patient's Signature

____
Guardian or Authorized Representative's Signature