MEI

MICHIGAN EYE INSTITUTE

Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

Please print all information. Form must be signed and dated each year.

Patient Name: _____ **Account #:** _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize the practice to disclose or provide protected health information about me to the individual(s) listed below.

Who will provide or disclose information: Michigan Eye Institute
4499 Town Center Parkway
Flint, MI 48532
(810) 733-7111

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record, or check only those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only)
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify):

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager in writing if you decide to terminate the authorization prior to the normal expiration date. (Please list date of expiration if earlier than end of calendar year):

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time in writing except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

patient signature date

_____ _____

patient signature date

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Name: _____

Birthdate: **Cell Phone:** **Home Phone:**

Address: **City/State/Zip:**

Email: _____

1.) I hereby authorize records FROM:

Name: _____

Address: _____

Phone: Fax:

2.) To be released TO:

Name: _____

Address: _____

Phone: Fax:

3.) Purpose of Disclosure: _____

4.) Records Format:	**5.) Specific Information to be released:**
☐ Paper Copies via postal mail	☐ All Records
☐ Electronic Access via Email	☐ Date Range:
☐ Fax (If under 20 pages)	☐ Other:
☐ Pick Up	

I understand authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I understand treatment will not be conditioned on my signing this authorization. I understand that any disclosure of my information carries with it the potential for an authorized re-disclosure and the information may no longer be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 6 months from the date signed.

I have read the information provided on this release form and do hereby acknowledge that I fully understand the terms and conditions of this authorization.

_____ _____

6.) Signature of Patient/Guardian/Authorized Representative **Date**

*We reserve the right to charge the fee schedule as set by the State of Michigan Records Access Act.

Revised 7/2018

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Patient Registration (Please Print)

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. ☐Rev. ☐Jr. ☐Sr. ☐III ☐IV

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

MEI uses email as a method of communication

Gender: **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

Social Security Number: _____ **Date of Birth:** _____

Doctor (Referred by) _____ ☐MD ☐DO ☐OD

Family Physician _____ ☐MD ☐DO

Address _____ **Phone** _____

Emergency Contact: _____ **Phone:** _____

First **Last** **Other than home (cell phone, etc.)**

Patient's Employer: _____ **Are you retired?** ☐Yes ☐No

Name of Insured: _____ **Insured's SS#:** _____

Insured's Employer: _____ **Retired?** ☐Yes ☐No

Insured's Work Phone: _____ **Insured's Date of Birth:** _____

I authorize the release of any medical information necessary to my referring doctor and any insurance company. I understand that I am responsible for any charges not covered by my insurance company.

In an effort to provide you the best healthcare service possible, Michigan Eye Institute will download medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Pharmacy Name _____ Address _____

Responsible Party Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

Address: ☐same _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Please mark ALL you are interested in:

☐Eyeglasses ☐Sunglasses ☐Contact Lenses ☐Laser Vision Correction ☐Cataract Surgery

☐Eyelash darkening/thickening ☐Freedom from Eyeglasses/Contacts ☐Eyelid Plastic Surgery (droopy lids)

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PATIENT HISTORY (Please Print)

HOW DID YOU HEAR ABOUT OUR PRACTICE? (First time patients only)

☐ **YELLOW PAGES** ☐ **INSURANCE** ☐ **INTERNET/WEBSITE (mieye.com)** ☐ **DRIVE-BY/WALK-IN**

☐ **PATIENT** _____ ☐ **DOCTOR** _____

name and relationship to

MEDICAL CONDITIONS - Past or Present (diabetes, high blood pressure, arthritis, heart attack, etc.)

☐ NONE

SURGERIES, INJURIES, HOSPITALIZATIONS (cataract, laser vision, eye injury, concussions, appendix, etc.)

☐ NONE

EYE DISEASES (glaucoma, cataract, "lazy" eye, retinal detachments, etc.)

☐ NONE

MEDICATIONS (dose and times/day) INCLUDE: eye drops, inhalers, vitamins, OTC (over the counter)

☐ NONE ☐ SEE LIST ARE YOU USING? ☐ PLAQUENIL ☐ FLOMAX ☐ GILENYA ☐ TAMSULOSIN

ALLERGIES INCLUDE: drug, food, latex, seasonal, etc.

☐ NONE

PLEASE TURN OVER →

REVIEW OF SYSTEMS

Do you CURRENTLY have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (poor vision, vision loss, eye pain, double vision, redness, burning, itching, tearing, gritty sensation, dryness, discharge, glare, halos, flashes, floaters, etc.)			
GENERAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (tuberculosis-TB, congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN PROBLEMS (acne, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (HIV+, hepatitis, bleeding, high cholesterol, anemia, blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
REPRODUCTIVE (pregnant, nursing, etc.)			

FAMILY HISTORY (Mother, Father, Sibling, Grandparent)

Do any eye diseases run in your family? (Blindness, Cataract, Glaucoma, Macular Degeneration, Retinal Detachments, etc.)	**YES**	**NO**	**If YES, please explain**
Do any medical diseases run in your family? (High Blood Pressure, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Diabetes, etc.)	**YES**	**NO**	**If YES, please explain**

SOCIAL HISTORY

Do you smoke? YES / NO If Yes, how much?_____ **How many years?**_____

Do you drink alcohol? YES / NO If Yes, how much?_____

Do you use a computer? YES / NO If Yes, hours per day?_____

Hobbies/Sports/Visual Needs:_____

Occupation (current / retired / disabled / student):_____

U S GOVERNMENT REPORTING I WOULD PREFER NOT TO DISCLOSE THIS INFORMATION ☐

Race:	☐ Amer. Indian	☐ Asian	☐ Black	☐ White	☐ Type Unknown
Ethnicity:	☐ Hispanic	☐ Non Hispanic	☐ Type Unknown		
Language:	☐ English	☐ Chinese	☐ French	☐ Hebrew	☐ Hindi
	☐ Japanese	☐ Portuguese	☐ Spanish	☐ Yiddish	☐ Type Unknown