Cleveland Sight Center
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www.clevelandsightcenter.org

Request and Authorization for the Disclosure of Protected Health Information to Cleveland Sight Center

Name of Client:	Client's date of birth:
Name of the parent (if a minor), or legal guardian*:	Telephone number:

I, or my parent (if I am a minor), legal guardian, or personal representative, authorize and request the individual, organization, or entity identified in Section A, to disclose to Cleveland Sight Center (CSC) the protected health information described in Section B. I understand and acknowledge that this may include information about physical and mental illness, alcohol/drug abuse, or HIV/AIDS test results, diagnoses, and treatments. I understand that I have the right to inspect and copy certain protected health information. I understand that, subject to the conditions described in CSC's Notice of Privacy Practices, I may revoke this Authorization at any time by notifying CSC in writing at the address above, but that this will have no effect on actions taken prior to the revocation. I may choose, in Section C, a date that this Authorization expires. If I do not choose an expiration date, this Authorization will expire one year from the date I signed the Authorization. I understand that CSC and its employees are released from any legal responsibility or liability for the disclosure of information authorized by my signature below. I also understand and acknowledge that once my health information has been disclosed, redisclosure of this information may no longer be protected by law.

A	Name and contact information of the individual, organization, or entity who is being authorized and requested to disclose information to CSC:	
B	Specific description of the information to be disclosed to CSC:	
	Reason(s) for the disclosure: (Please check applicable boxes, and describe the reason, if appropriate.)	☐ Coordination of care and services with another provider ☐ At the request of the client ☐ Other (describe):
C	Signature of the Client, or the Client's Personal Representative*:	
	Printed name:	
	Relationship (if not the Client)*:	
	Date signed:	
	Date this authorization is to expire:	

* If a person other than the client is signing, a copy of a legal document or documents that verify that the person signing is the client's personal representative (e.g., court appointed guardian, durable power of attorney for health care), **must** accompany this disclosure, **with the exception** of a parent who is signing for an individual who is under the age of eighteen.

* When a personal representative signs this form to authorize disclosure of a deceased client's information, this Authorization form **must** be accompanied by (1) a court entry or order appointing the person who is signing as the fiduciary, executor, or administrator; or (2) letters of appointment received from a Probate Court, and signed by the client. If the estate has not been probated, a death certificate is required, along with documents naming the person requesting disclosure as the the administrator or executor of the estate.

CSC staff: (1) Provide the client with a copy of this signed Authorization, and (2) scan and upload the signed Authorization into Carechart.