Precision Eye Care
Dr. Nicole Cremata, Dr. Reed West
2357 Overseas Highway, Marathon Florida 33050
305-743-6939 Phone, 305-743-6927 Fax

Authorization for request/Release of electronic Health Information:

As per the 21st Century Cures Act Final Rule requiring all optometrists to provide patient and patient's health care providers secure access to all applicable Electronic Health Information (EHI) including full Electronic Health Records with no "information blocking" as per outlined in the Final Rule.

Patient Name: _____ DOB:_____

Patient phone#:_____ Address: _____

By signing this authorization, I authorize Precision Eye Care to obtain, use and disclose specified Electronic Health Information at my request TO myself or my specified health care provider via fax or other authorized secured method of transmission, as well as the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected EHI under the terms of this specific authorization.

I understand I have the right to inspect, review and obtain a copy of my protected health information, electronic health information in the designated records sets Precision Eye Care and associates maintain. I understand, however, I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of the use of/or for any civil, criminal administrative action or proceeding, any information not subject to disclosure under the clinical laboratory improvements amendments of 1988, (42 U.S.C. section 263 (a) and certain other records)

THIS FORM WILL ONLY BE USED IN THE EVENT THAT YOU, YOURSELF, REQUEST ACCESS TO YOUR ELECTRONIC HEALTH INFORMATION (EHI) OR YOU REQUEST WE PROVIDE (EHI) TO YOUR SPECIFIED HEALTH CARE PROVIDER.

Each patient will sign a consent specifically pertaining to the 21st Century Cures Act Final Rule that will become part of the permanent EHR and ONLY PERTAINS TO ANY FUTURE REQUESTS BY THE PATIENT to have access to their EHI or at the request of the patient the EHI be provided to a specified Health Care Provider for transfer of care or continued care and treatment.

Signature: _____ Date: _____

I authorize _____ Do not authorize _____ Precision Eye Care to transmit my **glasses or contact lens prescription** via unencrypted email to my personal email address AT MY REQUEST. I understand I will be provided a copy of my prescriptions prior to leaving the office, if applicable.

Email address_____