HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use and disclosure of my health information as described below:

1. DESCRIPTION For this Authorization "my health information" is any and all information, including the complete medical record, regarding my physical or mental condition, treatment and/or confinement.

2. PARTIES I authorize The Eye Care Institute to disclose my health information to:

   ____

3. PURPOSE The purpose of the use or disclosure is to allow the recipient, or any agent or designee appointed by the recipient, to examine my health information in order to:

   ____

4. EXPIRATION OF AUTHORIZATION This authorization expires ______________________________

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the federal Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

____
(Printed Name of Patient)

Date of Birth: ______________________________ SSN: ______________________________

____
Signature Date

<u>If the patient is unable to sign, or is a minor, please complete the following</u>:

Patient is a minor, _________ years of age; ***or*** patient is unable to sign because

____

____
Signature of Closest Relative or Guardian Date

____
Print Name of Closest Relative or Guardian

Authority to sign on behalf of the patient is based on: _______________________________________

____.

ADDITIONAL CONSENT REQUIRED FOR CERTAIN CONDITIONS

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

❑ I consent to have the above information released.

❑ I do not consent to have the above information released.

____
Signature (Parent or Legal Guardian to Sign for Patient Unable to Sign or Minor) Date

ADDITIONAL CONSENT REQUIRED FOR HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

❑ I consent to have the above information released.

❑ I do not consent to have the above information released.

____
Signature (Parent or Legal Guardian to Sign for Patient Unable to Sign or Minor) Date

__________ ***[Initials of patient or guardian]*** I have been informed that [insert name of practice] may receive direct or indirect payment for the use or disclosure of my health information for marketing purposes.

1536 Story Avenue
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