HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Hartland Eye Care may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print):_____**DOB:**_____

I authorize Hartland Eye Care to use or disclose the following health information:

- All of my health information
- My health information relating to the following treatment/condition:

  _____
- My health information covering the period of healthcare from(start date)_____to (end date)_____
- Other:_____

Hartland Eye Care may disclose this health information to the following recipient(s):
Name/Organization:_____
Phone:_____ Email/Fax:_____

The purpose of this authorization is (check all that apply):

- At my request to release health information
- To obtain insurance information
- All of the above
- Other:_____

This authorization ends:

- On (date)_____ ☐When I am no longer a patient of the practice
- When the following event occurs: _____

My Rights

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 HIPAA 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.

The signature below indicates that I have been provided with a copy of this Notice of Privacy Practices for the authorized party listed above, and I have read and understand its content:

Signature of Patient _____ Date:_____

If patient is unable to sign:
Authorized Representative Signature:_____Date:_____
Printed Name of Representative:_____

☐Parent ☐Legal guardian ☐Court Order ☐Other_____