AUTHORIZATION to RELEASE PROTECTED HEALTH INFORMATION

HIPAA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization I authorize

DEEDE EYE CARE DeedeEyeCare@hotmail.com FAX 866-576-0458

To disclose the protected health information described below to:

PROVIDER: ____

ADDRESS: ____

FAX:

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2. Effective Period This authorization for release of information covers the period of healthcare from: a. □ ______________ to ______________.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**

b. □ I authorize the release of my complete health record with the exception of the following information: □ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify): __________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until 1 YEAR ,at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_______________________________________ ________________________

Name of Patient/Personal Representative Relationship to Patient

_______________________________________ ________________________

SIGNATURE DATE