AUTHORIZATION FORM

For Use and Disclosure of Protected Health Information

Patient Name_____Medical Record #_____

Date of Birth _____Social Security# _____

I, _____, hereby authorize Houston Eye Associates to Disclose the following protected health information to (specify the name of the individual or organization to receive information):

Name _____

Address_____

_____Phone number_____

The type and amount of information to be used or disclosed is as follows (check off the appropriate item(s), and include other information, where indicated):

- ❑ Problem list
- ❑ Laboratory results from _____(date) to _____(date)
- ❑ X-ray and/or imaging reports from _____(date) to _____(date)
- ❑ Medication list
- ❑ Consultation reports from (specify doctors' names and dates)_____
  _____
- ❑ Most recent history and physical
- ❑ List of allergies
- ❑ Entire medical record
- ❑ Other (please describe)_____
  _____

This information is being disclosed for the following purpose(s):_____
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Houston Eye Associates Privacy Officer to the following address: Houston Eye Associates Bldg, 2855 Gramercy Street Houston, Texas 77025.
I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by the federal or state law.

Unless otherwise revoked, this authorization will expire in six months or on the following date, event, or condition:
_____

I understand that Houston Eye Associates will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed.
- Refuse to sign this authorization.

If I have questions about disclosure of my health information, I can contact the Houston Eye Associates Privacy Officer (2855 Gramercy Street, Houston Texas 77025. Phone number: 713/558-8755).

Signature of Patient / Legal Representative_____ Date _____

_____
If signed by legal representative, include relationship to patient

Signature of Witness_____Date_____