HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices explains how Adamstown Eye Care, LLC may use and disclose your protected health information and when your written authorization is needed. This form is required to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Your protected health information may be shared with third parties as required by law for reasons related to your care. Adamstown Eye Care, LLC does not sell your information for research, tracking or promotional purposes.

Patient Name (print)_____ **Date of Birth** _____/_____/_____

Adamtown Eye Care, LLC may contact me regarding my care by the following methods (check all that apply):

____ Home Phone on file ____ Work Phone on file ____ Cell Phone on file

____ Text (SMS) to this number _____

____ email to this address _____

1. **My Authorization**

I authorize Adamstown Eye Care, LLC to use or disclose the following health information:

____ All of my health information

____ My health information relating to the following treatment or condition _____

____ My health information during the dates of care starting _____ and ending _____

____ Other _____

Adamstown Eye Care, LLC may disclose the above information to the following recipient(s):

Name of Recipient (print) _____ Phone _____

Name of Recipient (print) _____ Phone _____

Name of Recipient (print) _____ Phone _____

Additional recipients may be added in this space:

My Authorization Ends:

____ On (Date): _____

____ When I am no longer a patient of the practice

____ When the following event occurs _____

Please complete other side

2. My Rights

I understand that I have the right to revoke this authorization at any time, but not retroactively. 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 cannot be undone and that information used or disclosed to others with my permission may be re-disclosed by them and is no longer protected by the HIPAA Privacy Standards. I understand that my information is permitted to be used and disclosed for treatment, payment and health care operations in order to avoid interfering with my access to quality health care or efficient payment for care. 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 may ask to receive a copy of this authorization after I have signed it, which is as valid as the original.

Signature of Patient* _____ Date _____

*If the patient is a minor (under 18) or unable to sign on their own behalf, please complete this boxed area:

____ Patient is a minor of ____ years of age

____Patient is unable to sign because _____

Signature of Authorized Representative _____ Date _____

Name of Authorized Representative (print) _____

Representative is legally authorized to sign on behalf of patient as (check one):

____ Parent ____ Legal Guardian ____ by Court Order ____ Other (specify)_____

3. Additional Consent for Certain Conditions

My health record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion or mental health and separate consent must be given here before such information can be released.
To the release of such information, I (check one) ____ Consent ____ Do Not Consent

Signature of Patient _____ Date _____ Time _____

4. Additional Consent for HIV / AIDS

My health record may contain information about HIV testing and/or AIDS diagnosis or treatment and separate consent must be given here before such information can be released.
To the release of such information, I (check one) ____ Consent ____ Do Not Consent

Signature of Patient _____ Date _____ Time _____

5. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Adamstown Eye Care, LLC and have read and understood its content.

Signature of Patient _____ Date _____ Time _____