HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Family Optometry of Tracy 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): _____ Date of Birth: _____

I. My Authorization

I authorize _____ 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 covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ❑ Other:_____

The above party may disclose this health information to the following recipient:

Name/Organization: _____

Phone: _____ Fax: _____ Email: _____

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

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ❑ Other: _____

  _____

This authorization ends:

❑ On (Date): _____ ❑ When I am no longer a patient of the practice.

❑ When the following event occurs: _____

II. 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.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

- ❏ Patient is a minor: _____ years of age
- ❏ Patient is unable to sign because: _____

Authorized Representative Signature: _____ Date: _____

Print Name of Representative: _____

Authority of representative to sign on behalf of patient:

❏ Parent ❏ Legal Guardian ❏ Court Order ❏ Other: _____

III. Additional Consent 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 ❏ I do not consent

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent 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 ❏ I do not consent

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

V. Notice of Privacy Practices

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

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____