'Io Eye Center LLC
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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we 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.

Printed Name of Patient: _____ Date of Birth: ____ / ____ / ____

I. MY AUTHORIZATION:

I authorize 'Io Eye Center, LLC to disclose:

( ) All of my health information.

( ) My health information relating to the following treatment or condition:

_____

( ) My health information covering the period of healthcare from **____ / ____ / ____** to **____ / ____ / ____**

( ) Other: _____

'Io Eye Center, LLC may disclose this health information to the following recipient:

Name and/or Organization:

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

( ) At my request

( ) To provide pertinent health information that will enable the making of informed decisions regarding the care and/or treatment of anything associated with my health and wellbeing.

( ) Other: _____

This authorization end:

( ) On **____ / ____ / ____** , or

( ) When the following event occurs: _____

II. MY RIGHTS

I understand that I have a 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 understand** that uses and disclosures *already made* based upon my original permission *cannot be taken back*. **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 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 *at my request*. **A copy of this authorization is as valid as the original.**

( ) I do not want a copy ( ) Copy requested ( ) Copy given by: _____ (Staff Initials)

Patient's signature: _____ Date: ____ / ____ / ____

If 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: _____

Signature of Authorized Representative:

_____ Date: ____ / ____ / ____

Printed Name of Authorized 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 is released.

( ) I consent to have this information released

( ) I **do not** consent to have this information released

Signature of Patient or Authorized Representative:

_____ Date: ____ / ____ / ____

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 to have this information released

( ) I **do not** consent to have this information released

Signature of Patient or Authorized Representative:

_____ Date: ____ / ____ / ____