Northern California
Retina Vitreous Associates
Established in 1983

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.

Patient Name: _____ Date of Birth: _____

Address: _____ City / State / Zip: _____

I hereby authorize the disclosure of my health information from:

_____
Name of Person / Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number Fax Number

To release my information to:

_____
Name of Person / Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number Fax Number

Information to be released:

☐ Complete Medical Record
☐ Medical Records covering the period with these dates:
from: _____ to _____
☐ Other (please list):_____
_____

Purpose of Authorization (check all that apply):

☐ Further Medical Care ☐ Personal Use ☐ School
☐ Attorney ☐ Insurance ☐ Disability ☐ Research
☐ Other:_____
_____

If you would like any of the following information to be released, check the applicable boxes:

☐ Alcohol/Drug Abuse ☐ Physical/Sexual Abuse ☐ Sexually Transmitted Diseases
☐ Abortion ☐ Mental Health Treatment ☐ HIV/AIDS related treatment

This authorization will remain valid until I revoke it or until the expiration date or expiration event specified here:

_____

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____ _____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

For Internal Use Only *– Sent by (name)* _____ *on (date)* _____ *via (fax or mail)* _____