Clear Image Eye Center

AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ **Date of Birth:** ______________

Information to be Used or Disclosed: **Must Choose One**
( ) All Protected Health Information
( ) Just the last 2 years of Protected Health Information
( ) Pertinent to stated condition: _________________________________
( ) Other – as listed: ____
( ) None

Persons to Whom Information May be Disclosed:
We can not disclose any information to anyone other than patient unless listed below

____ _________________________
Name **Relationship to Patient**

____ _________________________
Name **Relationship to Patient**

____ _________________________
Name **Relationship to Patient**

Right to Terminate or Revoke Authorization
This authorization will remain valid unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Clear Image Eye Center. You should contact Kristi Meiring, Privacy/Compliance Officer, to terminate this authorization.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

____ _______________________
Signature of Patient Date

____ _______________________
Signature of Patient Representative Relationship to the Patient