HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **AUTHORIZATION**

I authorize Family Vision Care Associates, LLP, and all of its doctors and employees, to use and disclose the protected health information described below to:

_____ _____

Name Relationship

_____ _____

Name Relationship

2. **EFFECTIVE PERIOD**

This authorization for release of information covers the period of healthcare from:

a. ___ _____ to _____.

****OR****

b. ___ all past, present and future periods.

3. **EXTENT OF AUTHORIZATION**

a. ___ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. ___ I authorize the release of my complete health records with the exception of the following information:

___ Mental health records
___ Communicable diseases (including HIV and AIDS)
___ Alcohol/drug abuse treatment
___ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition or obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for the benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature

_____
Print

_____
Date