BISSELL Eye Care

HIPAA AUTHORIZATION FORM

I, _____, give permission to Bissell Eye Care to discuss or release health information identifying me to my insurance company/companies, to any referring or consulting physicians or entities, and to the following.

List of authorized people and entities (suggestions: parents, spouse, caretakers):

_____

_____

_____

Description of information to be produced: medical and financial (amount billed, payments, etc).

This authorization is being made voluntary and at my request.

I understand that:

If the above listed person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations (e.g. If you release your information to your spouse we have no control of what your spouse may do with the information).

I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, my right to access is suspended until the clinical trial is completed.

Bissell Eye Care has a comprehensive Notice of Privacy Practices available that describes these uses and disclosures in detail. I am free to refer to this Notice at any time.

Finally, I may revoke this authorization in writing at any time by notifying the office. My notice will not apply to actions taken prior to the date they receive my written request to revoke authorization.

I have read and understand the above information.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name Relationship/Authority

If you would like this authorization to expire note here (date/event):_____