HIPAA Authorization for Use or Disclosure of Health Information

Edward G Bryant IV OD PLLC – 607-257-1066

HIPAA Compliance Officer – Edward G Bryant IV

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.

Name of Patient (please print): _____

Date of Birth: _____ SSN: _____

1. **My Authorization**

I authorize the following using or disclosing party:

Clarity Eye Care with Dr. Bryant (Edward G Bryant IV OD PLLC)

To use or disclose the following health information.

___ All of my health information

___ My health information relating to the following treatment or condition:

_____

___ My health information covering the period of healthcare from:

Start date: _____ End date: _____

___Other: _____

The above party may disclose this health information to the following recipient:

Name or Organization: _____

Phone: _____ Fax: _____

Email: _____

Name or Organization: _____

Phone: _____ Fax: _____

Email: _____

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

___ At my request

___ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

___ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

___ Other: _____

This authorization ends:

___ On (Date): _____

___ When the following event occurs: _____

___ When I am no longer a patient of Edward G Bryant IV OD PLLC

2. <u>My Rights</u>

I understand that I have the 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 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 uses and disclosures already made based upon my original permission cannot be taken back.

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. A copy of this authorization is as valid as the original.

Signature of patient: _____Date: _____

If the 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:_____

Print Name of authorized representative: _____

Authority of representative to sign on behalf of patient:

___ Parent ___ Legal guardian ___ Court order ___ Other _____

clarity
Eye Care with Dr. Bryant

3. Additional Consent for Certain Conditions

These medical records 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 can be released.

___ I consent to have the above information released.
___ I DO NOT consent to have the above information released.

Signature of patient or authorized representative: _____
Date: _____ Time: _____

4. Additional Consent for HIV/AIDS

These medical records 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 the above information released.
___ I DO NOT consent to have this above information released.

Signature of patient or authorized representative: _____

Date: _____ Time: _____