Edward G. Bryant, OD
Kristy M. Dean, OD
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clarity
Eye Care with Dr. Bryant

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 describes 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: _____

1. **My Rights**

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. Upon my request, I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

2. **My Authorization**

I authorize the following using / disclosing party:

Edward G Bryant IV OD PLLC

To use or disclose information to the following recipient(s):

Name of authorized recipient: _____ Relationship: _____

Phone: _____ Fax: _____

Name of authorized recipient: _____ Relationship: _____

Phone: _____ Fax: _____

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The **purpose** of this authorization is (required):

☐ To authorize the release of information upon my request. This authorization will allow the disclosing party to use or disclose to the recipient the following information (check all that apply):

☐ All requested health information.

☐ My health information relating to the following treatment or condition(s):

_____

☐ My health information covering the period of healthcare from:
Date: _____ UNTIL Date: _____

☐ Other: _____

☐ 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 (required)**:**

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

☐ When the following event occurs: _____

☐ On (Date): _____

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 _____

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3. Additional Consent:

Certain information is subject to separate consent. Please carefully read and consider the sections below. By signing each of these sections, individually, you are consenting to the release of the section's appertaining information.

You may leave any section unsigned and the information it specifies will not be released.

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.

By signing below, I am consenting to have the above information released

Signature of patient or authorized representative: _____

Date: _____

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.

By signing below, I am consenting to have the above information released

Signature of patient or authorized representative: _____

Date: _____