Edward G. Bryant, OD
Frank E Visco Jr. OD, MS

Doctors of Optometry
1284 Dryden Rd
Ithaca, NY 14850
Phone: 607.257.1066
Fax: 607.257.1378

clarity
Eye Care with Dr. Bryant

www.bryantclarityeye.com

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: _____

Edward G. Bryant, OD
Kristy M. Dean, OD
Kayla Whelan, OD
Doctors of Optometry
1284 Dryden Rd
Ithaca, NY 14850
Phone: 607.257.1066
Fax: 607.257.1378
www.bryantclarityeye.com

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: _____

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 _____

NOTE: ADDITIONAL AUTHORIZATION WILL BE REQUIRED IN CIRCUMSTANCES REGARDING THE RELEASE OF INFORMATION ON HIV/AIDS, SEXUAL HEALTH, ALCOHOLISM AND DRUG ABUSE, AND/OR MENTAL HEALTH TREATMENT.