



# Eye Physicians and Surgeons, S.C.

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## DISCLOSURE OF HEALTH INFORMATION

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.

Patients Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give the following people listed below consent to obtain the following medical information, and will be in effect until written notice is given to be removed:

\_\_\_\_\_  
(First & Last Name) (Relationship)

- Medical Information
- Billing Information

\_\_\_\_\_  
(First & Last Name) (Relationship)

- Medical Information
- Billing Information

\_\_\_\_\_  
(First & Last Name) (Relationship)

- Medical Information
- Billing Information

### II. 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. 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: \_\_\_\_\_