AUTHORIZATION FOR USE OR DISCLOSER OF PROTECTED HEALTH INFORMATION

Patient Name :_____
Patient's Previous Name: _____
Date of Birth: _____

You may use or disclose the following health care information (check all that apply):

- ❑ All health care information in my health record
- ❑ Health care information in my health record for the dates of : _____
- ❑ Health care information in my health record relating to the following treatment or condition:

_____

- ❑ Other (X-rays, bills,) please specify dates: _____

You may disclose this health care information to:

Name or Business Name: _____
Address: _____ State: _____ Zip: _____

Reasons for this authorization (check all that apply):

❑ Insurance	❑ Transfer of care	❑ Moving out of the area
❑ Legal	❑ Specialist consult	❑ Personal file

This authorization ends:

- ❑ In 90 days from the date signed
- ❑ On the following date: _____
- ❑ When the following event occurs: _____

Your Rights:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the receiving business. Based upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  - Fill out a revocation form. A form is available from the Sauk Centre Eye Clinic
  - Write a letter to the business this form is being dispersed to. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may not longer protect it.

Date: _____ Print Your Name: _____

Patient or legally authorized individual signature: _____