envision eyecare llc

Authorized Disclosure of Private Healthcare Information

Please complete this form using BLACK INK.

Patient Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ **Date Of Birth:** _____

Purpose: This form is used to identify the family members, close friends, or other persons to whom we may disclose protected information about you or notify regarding your care. This form is effective for the duration of your care or until you provide further notice.

Instructions: Please list the person(s) to whom protected health information about you may be disclosed regarding your treatment. Note: You must provide NAME and RELATIONSHIP.

Name _____

Address (if available): _____

Telephone: _____ Relationship to Patient: _____

Name _____

Address (if available): _____

Telephone: _____ Relationship to Patient: _____

Messages may be left on my answering machine/voicemail. _____Yes _____No

PATIENT/AUTHORIZED PERSON SIGNATURE

I attest that protected health information related to my care and treatment may be disclosed to the person(s) identified above.

Patient/Authorized Person Signature: _____Date: _____

If adult Patient unable to sign due to injury: _____(Witness Signature)

AUTHORIZED REPRESENTATIVE: If a Patient's Authorized Representative signs this form, please complete the following:

Authorized Representative's Name: _____

Relationship to Patient & Reason for Signing: _____

--SEE REVERSE SIDE--

REVERSE SIDE OF:

AUTHORIZED DISCLOSURE of PRIVATE HEALTHCARE INFORMATION

Not to be used for Release of Medical Records

Redisclosure of Information by Recipient: I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Envision Eyecare, LLC.

Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Envision Eyecare, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if Envision Eyecare, LLC uses this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Prohibition of Conditions: Envision Eyecare, LLC may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.

Envision Eyecare Staff: Scan and retain both sides of this form for the Patient's health information record.