Authorization for _____
To Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____
Previous name: _____

I. My Authorization

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

☐ All health care information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition:
_____
☐ Health care information in my medical record for the date(s): _____
☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____
Address: _____City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify):
_____

☐ check only if Clearview Eye and Laser, PLLC request the authorization for marketing purposes
☐ check only is Clearview Eye and Laser, PLLC will be paid or get something of value for providing health information for marketing purposes

This authorization ends: (this document does not permit disclosure of health information created more than 90 days after the date it is signed.)

☐ in 90 days from the date signed
☐ on (date): _____
☐ when the following event occurs: _____
(no longer than 90 days from date signed)

II. My 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 or
- 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 [name of practice or health care facility] 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 [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Date Time

Last update: 04/08/04