Harkins Eye Clinic

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www.harkinseyeclinic.com

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of my individually identifiable health information as described below.

Name (prefix & suffix): _____

Date of Birth: _____

I authorize Harkins Eye Clinic to: ____ Disclose to ____ Obtain from

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

____ History and physical examination
____ Progress Notes
____ Lab Reports
____ X-ray reports
____ Consultation reports
____ Doctor's office notes
____ Entire medical record
____ Emergency Room Records
____ Discharge Summary
____ Discharge Instructions
____ Financial Records
____ Doctor's reports
____ Physical Therapy Records
____ Other

I specifically authorize the release of the following information related to testing, diagnosis, and/or treatment for (please initial applicable line): ____
HIV (AIDS virus), ____ sexually transmitted diseases, _____ mental health, or ____ drug and/or alcohol abuse.

Conditions, Further Uses and Disclosures. I understand that my Provider may not condition my right to receive health care or benefits on my signing this authorization. When my information is used or disclosed to other parties as instructed in this authorization, I understand that my Provider will not have the ability to monitor whether my health information may be further used or disclosed by such parties, and that my health information may no longer be protected by federal and state privacy laws.

Expiration. This authorization shall expire 12 months from the date of my signature unless I indicate a different date or a specific expiration event here:

Revocation. I understand that I have the right to revoke this authorization at any time by providing my Provider with written notice, sent by certified mail or hand delivery to the attention of the Privacy Officer at the following address: 830 N Alpha Street Grand Island, NE 68803

By Signing below, I acknowledge receipt of a signed copy of this authorization.

Printed Name _____ Date_____

Signature _____

Authority of Person Signing, if not Patient (i.e., parent, legal guardian) _____

Printed Name of Patient, if different than above _____