HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164

Patient Name: _____Date of Birth: _____/_____/_____

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis and hereby authorize and request Westchester Eye Care to release my health information (PHI) to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restriction(s) to releasing my PHI:

_____

_____

Purpose of Use:

- ❑ At the request of the individual
- ❑ Other: _____

I understand that I am entitled to a copy of Westchester Eye Care's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.westchester-eye-care.com or from the office directly. I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect five years from today's date at which time this authorization expires.

_____ _____

Signature of Patient Date: