HIPAA Consent

Authorization For Release of Information

Release of Protected Health Information to Friends and Family

I grant permission for my healthcare provider and their representatives of Austin Eye to discuss my care as it becomes relevant, using this disclosure form to share information about my healthcare or discuss financial information for payment on my account with family or friends.

_____ _____
Patient Name Date

Are there any specific people you would like the staff at Austin Eye to disclose medical/appointment information to?
WE WILL NOT SPEAK TO ANYONE THAT IS NOT ON THIS FORM, INCLUDING YOUR SPOUSE, PARENT, OR CHILDREN.

Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ ALL OR ☐ Appointment Information ☐ Surgical Procedure Information ☐ External Lab Results & Imaging

☐ Medical History ☐ Financial & Insurance Information ☐ Explanation of diagnosis and/or procedure

----------**OR**----------

☐ I **do not** want any of my information shared with family or friends.

Leaving Voice Messages
I wish to be called at home or on my cell phone regarding my medical care, follow-up, and account balances. The best telephone number(s) to reach me are:

_____ (home) _____ (other)

I do ☐, I do not ☐, give permission to leave relevant medical and/or billing information on my answering machine or voice mail.

I do ☐, I do not ☐, want relevant medical information shared with the person who may answer my telephone. Approved names listed in above section.

Social Media
When leaving a review of Austin Eye on social media platforms including, but not limited to, Google Reviews, YELP, and/or Facebook, I do ☐, I do not ☐, give Austin Eye permission to acknowledge and publically respond to my posting.

***This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Austin Eye. Revocation policy on back.**

_____ _____
Patient Signature Date

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Right to revocation. I have a right to **revoke** this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Austin Eye must receive the revocation in writing, and the revocation must include:

a) My name and address,
b) The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c) My desire to revoke this authorization, and
d) The date of the revocation, and my signature.

Austin Eye will accept written revocations of this authorization via:

- Certified U.S. mail: 11901 Jollyville Rd., Austin, TX 78759
- Facsimile at this number: 512-250-2612

*ALL revocations must be reviewed by appointed staff and are not effective until received by him/her.

I acknowledge this disclosure will remain active unless an expiration date is listed by the patient. If an expiration date is listed, Austin Eye can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

This authorization shall expire on _____.
*If left blank, I understand this document will not expire until revocation letter is rec