HIPAA Consent

Authorization For Release of Information

Patient Name: _____ Date: _____

Patient ID: _____

I understand that my provider is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize my provider or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. **Description of the information to be used or disclosed (check as appropriate):**

☐ **MY ENTIRE RECORD: (Please Note: If you check "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)**
I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, diagnoses, and account information. I understand that my record may contain sensitive information.

OR

☐ **My demographic information (check "All" or those that apply):**
☐ All ☐ Age ☐ Gender ☐ Telephone ☐ State/Zip Code Only
☐ Name ☐ Race ☐ Address ☐ Other _____

☐ **Medical Data/Information as related to (check all that apply):**
☐ Appointments
☐ Surgical Procedure Information
☐ Medical History
☐ Imaging and Diagnostic Testing
☐ External Lab Results and Imaging
☐ Financial and Insurance Information
☐ Other _____

2. **I do ☐, I do not ☐ authorize this information to be disclosed electronically.**

3. **Purpose(s) for disclosure of the information:**
_____

4. **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: 2700 Bee Cave Road, Austin, TX 78746
- Facsimile at this number: 512-250-2612

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

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5. **I fully understand and accept the terms of this authorization.**
I understand that a reasonable amount of time (not to exceed 15 days) may be required to retrieve my records. A fee may be charged according to TMA guidelines. The maximum fee will be **$25 for 1-20 pages and 50 cents for each page thereafter.** The fee will be payable in advance.

Please disclose the above information FROM:	**Send TO:**
Name/Entity: _____	Name/Entity: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Please release the information via: _____Mail _____Fax

_____ _____
Name of Patient Date of Birth

_____
Social Security Number

_____ _____
Patient Signature Date

Release of Protected Health Information