



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 (PHI) 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 health 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:

- My name and address,
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
- My desire to revoke this authorization, and
- 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 authorized Austin Eye staff and are not effective until they have been received and processed.



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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. Fees may be charged in accordance with applicable Texas law. 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:

Name/Entity: _____

Address: _____

Phone: _____

Fax: _____

Send TO:

Name/Entity: _____

Address: _____

Phone: _____

Fax: _____

Please release the information via:

Mail _____

Fax _____

Email _____ (if selected, complete acknowledgment below)

Email Address: _____

By requesting delivery via email, I understand that standard email is not secure, and my information could be intercepted, misdirected, or accessed by someone other than me during or after transmission. I understand I could instead choose delivery by mail or fax. I am requesting email delivery to the address above by my own choice and accept this risk. I understand that Austin Eye is not responsible for what happens to my information once it is sent to this email address.

Patient Initials: _____

Name of Patient

Date of Birth

Social Security Number

Patient Signature

Date