Rocky Mountain Eye Center, Inc.
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name _____ Guardian or Authorized Party Name (if applicable) _____

Social Security Number _____ Date of Birth _____

I authorize the use and disclosure of my health information on as described below:
Information Requested:

_____ Records relating to treatment dates from: _____ to: _____

_____ Records for all care at this facility or by this doctor.

_____ Other (Please Specify) _____

Reason for this request: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing; without my express revocation this consent will automatically expire one year from today's date.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released [ ] from [ ] to _____

_____

_____

[ ] from [ ] to Rocky Mountain Eye Center, Inc.
27 Montebello Rd.
Pueblo, CO 81001
(719) 545-1530
Fax: (719) 542-6852

_____ **(Initials of patient or guardian)** I understand that Rocky Mountain Eye Center, Inc., may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient or Guardian ** _____ Date _____
A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO_____ DO NOT_____ authorize the release of this information.
** If this authorization is signed by an individual's personal representative, the representative's authority is based on:
_____ (e.g., state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $18.53 for the first ten pages and $.85 for pages 11-40 and $.57 for pages 41 and above. No fee shall be charged for reproducing and forwarding records directly to other physicians.

For office use only:
Physician Authorization _____ Date sent: _____ By: _____