ROCKY MOUNTAIN EYE CENTER, INC.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Authorized Disclosure Statement

I authorize Rocky Mountain Eye Center, Inc., through its physicians and staff, to disclose individually identifiable health information relating to me, which is called "protected health information" (PHI) under the Health Insurance Portability and Accountability Act (HIPAA), including information about my medical condition, medical needs, appointments, and billing account information to the individual(s) listed below.

I release Rocky Mountain Eye Center, Inc., its physicians, and staff, from any claim of breach of confidentiality in connection with the release of such information.

I consent to disclosure of my protected health information to the following family member(s) or person(s):

❒ No one

1. Authorized Person: _____ Relationship: _____

   Phone Number: _____ (home/cell/work)

2. Authorized Person: _____ Relationship: _____

   Phone Number: _____ (home/cell/work)

You may leave messages on my voice mail or answering machine to confirm appointments and report any normal test results.

Number 1:_____   Number 2:_____

Patient's Signature: _____**Date**:_____
(*Or Personal Representative – POA or other legal proof of authorization must be provided.*)
This authorization is valid until revoked by me in writing.

AUTHORIZATION FOR CARE
✓ I authorize RMEC (Rocky Mountain Eye Center, Inc.) providers to provide care as they deem appropriate.
✓ I authorize RMEC to release protected health information to my insurance company as needed for claims to be processed.
✓ I understand that I am responsible for full payment (less any adjustments that RMEC is contractually required to make) within 30 days of receipt of my statement.
✓ I authorize payment of all third party payor benefits to RMEC.

_____   _____
                            Signature   Date

PATIENT NAME: _____   **DOB:** _____/_____/_____
                        (*Please Print*)