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 _________________________________

____

____

Phone: ______________ Fax: ________________

[ ] from [ ] to Rocky Mountain Eye Center, Inc.
27 Montebello Rd.
Pueblo, CO 81001
Phone: (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 per page for pages 11-40 and $.57 per page 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: __________________