HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our notice of Privacy Practices provides information about how Riverton Vision Center, P.C may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____

Date of Birth:_____

I. My Authorization

I authorize **Riverton Vision Center** to use or disclose the following health information:

☐ All of my health information

☐ My health information relating to the following treatment or condition:

_____

☐ My health information covering the period of healthcare from _____(Start Date) to _____ (End Date).

☐Other: _____

The above party may disclose this health information to the following recipient:

Name/ Organization: _____

Phone: _____ Fax:_____ Email:_____

The purpose of this authorization is (check all that apply):

☐ At my request

☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ To authorize the using disclosing party to sell my health information. I understand that the seller will sieve compensation for my health information and will stop any future sales if i revoke this authorization.

☐ Other: _____

_____

This authorization ends:

☐ On (Date): _____ ☐ When i am no longer a patient of the practice

☐ When the following event occurs: _____

(Continued on back)