Authorization for the Use or Disclosure of Protected Health Information

Eye Center of Northern Colorado, P.C.
1725 E. Prospect Rd
Fort Collins, Co. 80525

As Required by the Health Insurance Portability and Accountability Act of 1996, Eye Center of Northern Colorado, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization in writing, at any time, except where uses or disclosures have already been made based upon your original permission.

AUTHORIZATION SECTION

I, _____(printed name) DOB _____ hereby authorize the (use/disclosure/use and disclosure) of the following health information that pertains to me.

☐ All of my health information

☐ My health information covering the period of healthcare from (date) _____ to (date)_____:

I authorize the following using or disclosing party:
Eye Center of Northern Colorado Personnel

The above party may disclose this health information to the following family recipient(s) if requested:

Name_____relationship:_____

Name_____ relationship:_____

Name_____ relationship:_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. This authorization expires 1 year after date of signature or when revoked in writing.

_____ _____

Signature Date