Eye Foundation of Utah

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 as described below:

Information Requested:

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

_____ Records for all care at this facility and/or doctor.

_____ Other (Please Specify) _____

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 the uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days 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 Eye Foundation of Utah
201 East 5900 South, Ste 201
Salt Lake City, UT 84107
Phone: (801)268-6408
Fax: (801)262-9216

_____ (Initials of parent or guardian) I understand that the Eye foundation of Utah 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 $15.00 for the first ten pages and $.30 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.