HESTER OPHTHALMOLOGY

Name: _____Date of Birth: _____

Authorization for use or Disclosure of Protected Health Information.

(Required by the Health Insurance Portability and Accountability Act, HIPAA, 45 C.F.R. Parts 160 and 164.)

I understand that I am not required to sign this form and that my treatment or payment will not be conditioned on whether I sign this authorization.

I _____, authorize Hester Ophthalmology and Darrell E. Hester, M.D. to use and disclose my protected health information as described below to the following individuals:_____

_____

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Effective period: This authorization for release of information covers (check one):

- ☐ the period of healthcare from *(date)* _____ to *(date)* _____
- ☐ All past, present, and future healthcare

Extent of Authorization: I authorize the release of (check all that apply):

- ☐ My complete health record.
- ☐ My complete health record except for the following:
  - ☐ Mental health records
  - ☐ Alcohol/Drug abuse treatment
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Other (please specify):_____

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient