ARVADA EYE ASSOCIATES
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH CARE INFORMATION

By signing this form, I _____, authorize the use and disclosure of my health information as described below:

1. Any information in the health care record for the purpose of Healthcare operations.
2. Any staff member or employee at the time of request.
3. Pharmacies, other physicians, optical shops, hospitals, contact lens laboratories, attorneys, legal counsel, collection agencies, and electronic billing services.
4. Primary Care Physician, including reports, letters, chart notes.

   Please Initial: _____Yes _____NO

5. This authorization expires three years after signed date.
6. You may release my personal health information to:_____

(spouse, relative, guardian or other, etc..)

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 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 and send it to ARVADA EYE ASSOCIATES, Nicole Perrine, 7950 Kipling Street, Suite 203, Arvada CO 80005.

I understand that it is possible that the information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the Federal Privacy Standards.

_____(Please Initial) I understand that ARVADA EYE ASSOCIATES 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

_____
Print Name of Patient

_____
Print Name of Guardian

**

If an Authorization is signed by an Individual's personal representative, the representatives authority is based on_____(e.g., state law, court order, POA, etc.)