

**THE CHILDREN'S EYE CENTER HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE
OF HEALTH CARE INFORMATION**

**8890 N. Union Blvd. #205
Colorado Springs, CO 80920
Telephone: 719-574-1654
Fax: 719-574-5381**

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

1. Description of Information: _____

**2. Name the people and/or organizations that you are authorizing to use and/or disclose the protected health information described above.
REQUESTING INFORMATION FROM:**

**THE CHILDREN'S EYE CENTER
8890 N. Union Blvd. #205
Colorado Springs, CO 80920**

**3. Name the people and/or organizations that you are authorizing to receive and use your protected health information:
(e.g., doctor, patient, parent, legal guardian, attorney, school, other...)**

4. Date or event when authorization expires: _____

5. Description of each purpose of the requested use or disclosure:

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 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:

THE CHILDREN'S EYE CENTER
8890 N. Union Blvd. #205
Colorado Springs, CO 80920

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

_____ (Initials of patient, parent or legal guardian) I understand that The Children's Eye Center may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient, Parent or Legal Guardian**

Date

Print Name of Patient

Date of Birth

Print Name of Parent or Legal Guardian

Date of Birth

** If an authorization is signed by an individual's personal representative, the representative's authority is based on: _____

_____ (e.g., state law, court order, etc.)