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:
(e.g. doctor, patient, parent, legal guardian, attorney, school, other...)

_____

_____

3. Name the people and/or organizations that you are authorizing to receive and use your protected health information:

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

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 bylaw 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.)