Eye Surgery Associates

Authorization to Discuss Protected Health Information

I, _____, authorize Eye Surgery Associates to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons. (It is not necessary to list physicians with whom you are undergoing care. List names of family members and/or close friends that assist you in your medical care and/or handle your medical bills).

1) _____ 3) _____

2) _____ 4) _____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict or expand this listing at any time. You are not required to list any name if you do not choose.

Please list phone numbers where you would like us to contact you for:

- Test Results Reminder notices Changed scheduled appointments

  1) _____ 2) _____

HIPAA Privacy Notice:

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Receipt of acknowledgement:

_____ _____

Patient Signature Date

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