Verdier Eye Center

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LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA PRIVACY RULE)

Please print all information. Form must be signed and dated each year.

Patient Name _____ SSN (last four digits) _____ Date of Birth_____

Purpose of request (who will be authorized to receive information) - I authorize **Verdier Eye Center, PLC** to disclose or provide protected health information (PHI), about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Name	Relationship	Address	Phone Number (s)

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or,** check **only** those items of the record to be disclosed:

☐ office notes records
☐ lab results, pathology reports
☐ x-rays
☐ financial history report (previous 3 years only)
☐ nursing home, home health, hospice, and other physician
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only send the following:_____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request
☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient signature: _____ Date: _____

If not the patient, state your name and relationship. (If POA or guardian, please bring a copy for our records.)