Disclosure of Health Information

POLARIS
EYE CARE

Print name of patient: _____

Date of Birth: _____

I. My Authorization

a. I authorize **Polaris Eye Care** to use or disclose the following health information: (Please check one)

- ○ All of my health information
- ○ My health information relating to the following treatment/condition:

_____

b. This information may be disclosed to the following recipient:

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosure have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send to the appropriate disclosing party.

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

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following: (Please check one):

- Patient is a minor: _____ years of age
- Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date:_____

Print Name of Representative: _____

Relationship of representative: _____