Eye Doctor, MD, P.C.

Patient Name: ____ DOB: _____________________

Release of Information Form
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I. My Authorization
I authorize the following using or disclosing party:____
to use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition: ______________________________

☐ My health information covering the period of healthcare from (date) _____________ to (date)_____________

☐ Other:____

The above party may disclose this health information to the following recipient:

Eye Doctor MD PC – Dr. Shilpi Pradhan
3960 Stillman Parkway, Suite 120
Glen Allen, VA 23060
Ph: 804-270-3333
Fax: 804-270-9333

The purpose of this authorization is (check all that apply):

☐ At my request
☐ Other: ____

This authorization ends: ☐ On (date)____________
☐ When the following event occurs:____________________
☐ Until revoked in writing.

II. My Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures 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 it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.
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.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it if requested. A copy of this authorization is as valid as the original.

Signature of Patient: ____ Date: _____________________________