CHENANGO EYE ASSOCIATES

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

As required by the Health and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

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Patient Name (print): _____ **Date of Birth:** _____

Phone: _____ Address: _____ City: _____ St: _____ Zip: _____

Information to be released:

☐ FROM: ☐ TO: _____

_____

_____

_____

_____

☐ FROM ☐ TO Chenango Eye Associates
194 Grandview Lane
Norwich NY 13815
P: 607-334-3225 F:607-334-5946

I authorize the release of:

☐ **ALL** of my Health Information ☐ Include previous provider records

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

☐ My health information for the date(s): _____

☐ Other: _____

Reason for release: ☐ Continued Medical Care ☐ Leaving Practice ☐ Legal ☐ Other: _____

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law. I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. Check **ALL** Requested Exclusions: ___Alcohol/Drug ___Behavior/Mental Health/Psychiatric ___Sexually Transmitted Disease ___HIV/AIDS ___Other; specify exclusion: _____

I understand that I have the right to request that a service for which I have paid out of pocket, not be disclosed to my health plan.

☐ This Authorization is Effective for all past, present, and future periods.

☐ Valid from: _____
(Dates must be specified, or this authorization will be valid for (1) one year from date of signature)

SIGNATURE: _____ **DATE**: _____
(Patient/Guardian/Parent/Patient's Representative)

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REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released. I understand that I may revoke this authorization at any time by notifying the X in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken the X prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re- disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS---related information, and psychiatric/mental health information.