AUTHORIZATION FORM FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name

Record/Account Number | Social Security Number | Date of Birth

Street Address | City, State, Zip Code | Phone

Check One Option Below:

[ ] I, the undersigned, hereby authorize Vital Tears to use and/or disclose the above-named patient's protected health information to the following health care provider, person or agency.

[ ] I, the undersigned, hereby authorize Vital Tears to obtain the above-named patient's protected health information from the following health care provider, person or agency.

Note: *Vital Tears may release or obtain the above-named patient's protected health information in either verbal and/or written form.*

Name of Health Care Provider, Person, or Agency

Street Address | City, State, Zip Code

Phone | Fax (if needed)

Purpose for release of information:

[ ] Diagnostic Summary **[ ]** Legal **[ ]** Payment/Insurance

[ ] Educational/Employment/Social Services **[ ]** Personal Use (*only the patient can check this box*)

[ ] Other:_____

Provide the records by means of: [ ] Mail **[ ]** Email **[ ]** Fax **[ ]** Pick-up

Specific Information to be Released (check all applicable information to be released*):

[ ] Order Form **[ ]** Lab Requisition Form/Collection Details Form **[ ]** Laboratory Data **[ ]** Summary of Record Set
[ ] Billing Records **[ ]** Entire Designated Record Set

[ ] Other:_____

From:_____ (Date range of records needed from)

To:_____ (Date range of records needed to)

Certain sensitive medical record information is afforded a higher level of confidentially by state and federal law. Vital Tears will not release records addressing HIV/AIDS diagnosis or treatment unless you initial the line next to that specific type of information below.

PLEASE INITIAL FOR RELEASE: _____ HIV/AIDS

Authorization for Uses and Disclosure Form

▪ REVOCATION: I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Vital Tears HIPAA Privacy Officer. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. Further, I understand that actions taken in reliance on this authorization cannot be reversed, and my written revocation will not affect those actions.

▪ REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or federal law may require the recipient to obtain your authorization before further disclosure.

▪ DURATION OF AUTHORIZATION: THIS **AUTHORIZATION WILL EXPIRE WITHIN** _____(insert #(s) years/months) of the date of execution unless otherwise revoked for the following date, event or condition:_____.

▪ FEES: I understand that there may be fees associated with re-disclosures, excluding for direct patient care (*i.e.*, practitioner to practitioner communication). If advance notice of cost is desired, **PLEASE INITIAL HERE**: _____; otherwise you will be billed for this service. After you receive notice of any applicable charges, you may cancel this request without charge.

▪ I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment; or eligibility for benefits unless allowed by law. I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosures and the information may not be protected by federal confidentiality rules.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Patient Signature Date

_____ _____

Authorized Representative Date

If signed by a personal representative, a description of the representative's authority to act on behalf of the patient is as follows:

[ ] Legal Guardian **[ ]** Power of Attorney **[ ]** Next of Kin Deceased **[ ]** Executor of Estate