HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) PURSUANT TO 45 CFR 164.508

Patient Name: _____

Patient Address:_____

Date of Birth:_____ Date:_____

TRANSFER PROTECTED HEALTH INFORMATION (PHI) To:

Doctor/Clinic: _____

Address:_____

Phone:_____ **Fax:**_____

PROTECTED HEALTH INFORMATION (PHI) TO BE DISCLOSED:

- ❑ Record of last exam
- ❑ Spectacle prescription
- ❑ Contact lens prescription
- ❑ Entire record

From: Eyecare Associates of Ankeny
111 NW 9th Street Ankeny IA, 50023
Phone: 515 964-7355 Fax: 515 964-8413

Term: This Authorization will remain in effect from the date of this Authorization until the Doctor/Clinic fulfills the request. By my signature below, I hereby authorize the Doctor/Clinic to use or disclose to the Recipient my PHI for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

At the request of the patient: I understand that once the Doctor/Clinic discloses my PHI to the Recipient in accordance with the terms and conditions of this Authorization , the Doctor/Clinic cannot guarantee that the Recipient will not re-disclose my PHI to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my PHI. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Recipient's treatment of me; except, however, if my treatment at the Recipient is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Recipient may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that the Recipient may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Recipient at the address listed above. The revocation will be effective immediately upon the Recipient's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Recipient in reliance on this Authorization before it received my written notice of revocation. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. I hereby, knowingly and voluntarily, authorize the Doctor/Clinic to use or disclose my PHI to the Recipient in the manner described above.

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Signature of Patient or Legally Authorized Representative Date