CNY
Eye Care

AUTHORIZATION FOR USE AND DISCLOSURE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

I acknowledge that *The HIPAA Notice of Privacy Practices* brochure has been presented to me. I understand that I have the right to authorize how my identifiable health information is used or disclosed. I hereby authorize CNY Eye Care to release health information identifying me to the following persons:

Name: _____ Name:_____

Phone #:_____Relation:_____ Phone #:_____Relation:_____

I authorize CNY Eye Care to be able to leave messages for appointments or other medical information on:

	Appointment Information	Medical Information
Answering machine?	Yes / No	Yes / No
Cell Phone?	Yes / No	Yes / No
Office Voicemail?	Yes / No	Yes / No
Persons listed above?	Yes / No	Yes / No
Send through mail?	Yes / No	Yes / No
Send through e-mail?	Yes / No	Yes / No

Email Address:_____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. .

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law limits this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature:_____ Date Signed:_____