7.31 Limited Patient Authorization for Disclosure of Protected Health Information

Type of Authorization: Release of patient's protected health information to a designated person/caregiver.

Name of Practice: THE EYE GROUP OF SOUTHERN INDIANA

Patient Name (please print)_____ SSN **#**_____

Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information, about me or above minor patient, to (please identify person or persons who may receive the information)**:**

1._____ **3.**_____

2._____ **4**._____

(Please note with a minor child, both parents have the right to receive information unless there is a court order stating otherwise.)

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about the person identified above:

1. Diagnoses and findings **2.** Treatment and care **3.** Prognosis **4.** Billing/Payment Info **5.** _____

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Purpose of disclosure X request of patient (or minor patient's guardian or representative) **Other**_____

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Expirations or termination of authorization – This authorization will expire one year from the date of signature, except in the case of a minor patient where it will expire when the patient is of legal age to request medical treatment without parental consent. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

The Eye Group of Southern Indiana
1020 W. Buena Vista Rd.
Evansville, IN 47710
Attn: Privacy Manager

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

This practice places no condition to sign this authorization on the delivery of healthcare or treatment.

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Signature of patient or patient's parent/guardian/representative **Date**

Printed name of patient or patient's representative_____

Relationship to the patient_____