SYRACUSE EYE CENTER
612 University Avenue
Syracuse, NY 13210
Tel (315) 422-2020 Fax (315) 422-7339

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Syracuse Eye Center to use and/or disclose certain protected health information (PHI) about me as described below:

***__The following individual or organization is authorized to make the disclosure:__**

____ Syracuse Eye Center
____ Other (Specify name & address) _____

_____

***__This information may be disclosed to and used by the following individual or organization:__**

____ Syracuse Eye Center
____ Other (Specify name & address) _____

_____

***This authorization permits Syracuse Eye Center to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service(s), type of service(s), level of detail to be released, origin of information, etc.):

_____

_____

***The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____. (If I do not specify an expiration date, event or condition, this authorization will expire in six months from date signed.)

The practice will ___ /will not _X_ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment from Syracuse Eye Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer for the individual or organization I authorized above to disclose my health information.

Signed By:

*** _____ Signature of Patient or Legal Guardian

*** _____ Relationship to Patient

*** _____ Patient's Name (if not same as above)

*** _____ DOB

*** _____ Print Name of Patient or Legal Guardian

*** _____ Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST