Eye Center of Northern Colorado, P.C.,
AUTHORIZATION FORM
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

The Eye Center of Northern Colorado, P.C., is requesting your authorization to use or disclose your health information. The following is information about the health information at issue, to whom it will be disclosed, how we will otherwise use or disclose your health information if you sign this form and your rights with regard to this Authorization. The last page of this form is the signature page that we request you sign to provide us your authorization to use and disclose your health information as described in this form.

1. **Specific description of the health information:**

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2. **Persons/classes of persons who are authorized to use, or make the requested disclosure:**

____

Any authorized Eye Center of Northern Colorado staffmember

3. **Persons/classes of persons authorized to receive the health information:**

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4. **Describe purpose(s) of the requested use/disclosure:**

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5. **Expiration Date/Event:** This Authorization will expire on:

____

____

6. **Right to Revoke:** I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver

My request to:	With a copy to:
Privacy Officer C/O ECNC	Authorized Individual
1725 E. Prospect Road	
Fort Collins, CO 80525	

Exceptions To Right of Revocation: I understand that my written revocation will not affect the ability of the Physician Office to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, the Physician Office cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

7. **Prohibition on conditioning of authorization:** The Eye Center of Northern Colorado, P.C.("Physician Office") cannot condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the Physician Office is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

8. **Potential for redisclosure:** Your health information disclosed according to this authorization will no longer be protected by the federal privacy law (known as "HIPAA"), and the recipient of the information may potentially redisclose it.

9. **This Authorization is binding:** The statements made in this Authorization are binding, controlling and I understand that they take precedence over statements made in the Physician Office's Notice of Privacy Practices.

[Signature Page on Next Page]

<u>AUTHORIZATION SIGNATURE PAGE</u>

Authorization Approval:

I hereby authorize the use or disclosure of the health information described in this Authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is redisclosed by that recipient person or Physician Office.

Signature: ______________________________
Print Name: ______________________________
Address: ______________________________
____
Date: ______________________________

Basis for legal authority to sign this Authorization by a personal representative:

____
(parent, guardian, etc.)

Witness:

Signature: ______________________________
Print Name: ______________________________
Date: ______________________________

Acknowledgement:

I acknowledge receiving a signed copy of this Authorization.

Signature: ______________________________
Print Name: ______________________________
Date: ______________________________