

Authorization to Use or Disclose My Health Information

Patient name: _____

Date of birth: _____ EPA Record Number: _____

I. My Authorization

You may use or disclose the following health care information:

- All my health information maintained by you
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____
- Other: _____

If my medical records include information regarding HIV/AIDS, drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO _____ DO NOT _____ authorize the release of this information.

Information to be released [] from [] to _____

[] from [] to Eye Physicians of Austin, PA
5011 Burnet Road
Austin, TX 78756
(512) 583-2020
Fax: (512) 744-2020

Reason(s) for this authorization (check all that apply):

- _____ **Switching Eye Doctors**
- _____ **Disability, Workers Comp., Etc.**
- _____ **Moving Out of the Community**
- _____ **Other:** _____

This authorization is good for ninety days or until the following date or event: _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to the address provided above. If I do, it will not affect any actions already taken by Eye Physicians of Austin, PA based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I may receive a copy of this authorization upon my request. A copy of this authorization is as valid as the original.

Patient or legally authorized individual signature Date EPA Witness Date

Patient is unable to sign because of: _____
Age of minor or reason for patient's inability to sign

Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, etc.)