

# Authorization for Eye Physicians of Austin, PA 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.)