The Eye Institute Of West Florida

For Office Use Only
Patient Name: _____
Account #: _____

HIPAA Authorization Form

I. Information About the Use or Disclosure

Patient Name: _____ Date of Birth: _____

I hereby authorize the use and disclosure of my Protected Health Information ("PHI") as described below.

The Eye Institute of West Florida is authorized to use and/or disclose my PHI as follows:

(List the individual(s) or entity authorized to receive your information)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

What information may be used and/or disclosed to the above listed individual(s) or entity:

Check one: ☐ All of my protected health information *OR* ☐ Other: _____

Unless otherwise noted, the above uses and disclosures are made at the request of the individual, and this authorization will expire one year from the date the authorization is signed.

II. Important Information About Your Rights

I understand that:

- This authorization is voluntary, and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration, except to the extent that action has already been taken in reliance on it, by sending a written revocation notice to:

The Eye Institute of West Florida
1225 West Bay Drive, Largo FL 33770
Attn: Medical Records

Fax: 727-450-3062
Email: med.records@eyespecialist.com

- I am not required to sign this authorization as a condition to receive treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed under this authorization may be redisclosed by the recipient and, upon redisclosure, no longer be protected by federal privacy laws, if the recipient is not a HIPAA covered entity or business associate (*For example, if you allow a relative to have access, the relative is not a HIPAA covered entity and could potentially redisclose the information*).
- I can add or remove names of individuals or entities that I list at any time, by updating this form and delivering the updates to the appropriate staff member at: *Same address as above.*

III. **Signature of Patient or Patient's Representative**

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

If the form is signed by a personal representative (*must provide proof*), complete the following information:

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority to act as personal representative: _____