

Complete Eye Care, Inc.
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE
INFORMATION

Patient Name

Guardian or Authorized Party Name

Social Security Number

Date of Birth

I authorize the use and disclosure of my health information as described below:

Information Requested:

_____ Records relating to treatment dates from: _____ to _____

_____ Records for all care at this facility or by this doctor

_____ Other (please specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where use or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law have the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released { } from { } to _____

{ } from { } to Complete Eye Care, Inc.
9890 Clayton Road, Suite 200
St. Louis, MO 63124
Phone # 314-395-9613 Fax # 314-395-9621

_____ (Initials of patient or guardian) I understand that Complete Eye Care, Inc. may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

Signature of Patient or Guardian Date

A fax copy or photocopy of this consent shall be as valid as the original.

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

**If an individual's personal representative signs this authorization, the representative's authority is based on _____ (e.g. state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee changes every February 1 (see Missouri section 191.227).

State of Mo. sets the base rate of \$22.82 plus \$.53 per page for 2013 for copying medical records.

For office use only:

Physician Authorization: _____ Date Sent: _____ By: _____