Eye Associates of Lancaster**:** Patient Authorization Form

**Patient**_____**EA#** _____

Eye Associates of Lancaster Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The Terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Eye Associates of Lancaster provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

# PLEASE READ

**The Authorized Use and/or Disclosure (optional)**

The Contact Name is someone personal to you, someone we could disclose your medical, billing, claims, prescription, surgical information, and any/or all information that Eye Associates of Lancaster deems relevant to your case. lf for some reason you would like only to release part of your information please explain beside the person's name ***The contact person named by you will be given access to ALL your information unless otherwise specified.*** **I** hereby authorize Eye Associates of Lancaster to release to the persons and/or organizations listed below the information identified above.

**Contact Name: Please Print**

**1.** Last, First Name:_____Relationship _____

**2.** Last, First Name:_____Relationship _____

**3. Organizations:**_____**POA** _____

**Eye Associates of Lancaster has permission to contact you and or leave message with:**

**PLEASE CIRCLE YES OR NO!**

Home YES NO / Answering Machine YES NO / Work YES NO / With Family Member YES NO

**The Patient Understands that:**

1. Protected health information may be disclosed or used for treatment, payment or health care operations. 2. Eye Associates of Lancaster has a Notice of Privacy Practices that the patient has the opportunity to review this Notice. 3. Eye Associates of Lancaster reserves the right to change the Notice of Privacy Policies. 4. The patient has the right to restrict the uses of their information but Eye Associates of Lancaster does not have to agree to those restrictions. 5. The patient may revoke this consent in writing at any time future disclosures will then cease. Eye Associates of Lancaster may condition treatment upon the execution of this consent.

**Patient / Representative**

**Signature** _____**Date** _____/_____/_____

*The patient's Personal Representative is to sign if the patient is a minor or cannot sign for his/her self.

Witness_____Date_____/_____/_____EA Employee_____Other _____