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Authorization for Cornea Consultants of Arizona to Use or disclose my Health Information

Patient name:_____ Date of Birth:_____ Previous name: _____

I. My Authorization

You may use or disclose the following health care information:

☒ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted:_____

☐ You may disclose this health information to:

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: 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 understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)