HIPAA Privacy Disclosure Authorization Form

Medical information may be used by relatives or other person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I authorize the Retina Group of New York to use and disclose the protected health information described below to the following individual(s):

Name	Relationship	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
This authorization shall be in force indefinitely unless I indicate an expiration date.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State Law.

_____ _____
Signature of patient/personal representative Date

_____ _____
Printed name of patient/personal representative and his or her relationship to patient Date

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