HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164.)

I authorize **Chelsea Vision Care** to use and disclose the protected health information described below to the following:

_____	_____
(Name)	*(Relationship)*
_____	_____
(Name)	*(Relationship)*
_____	_____
(Name)	*(Relationship)*

This authorization for release of information covers all past, present, and future periods.

I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

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 than 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 conditional 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 or Personal Representative)	*(Date)*
_____	_____
(Print Name of Patient or Personal Representative)	*(Relationship to Patient)*