Delaware Eye
INSTITUTE
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HIPAA AUTHORIZATION FOR USE AND DISCLOSURE FORM

Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
Previous Name(s): _____ Medical Record #: _____

1. Authorization

You may use or disclose the following health care information (check all that apply):

□ All health care information in my medical record

□Health information in my medical record relating to the following treatment or condition:

_____

□ Health care information in my medical record for the date(s):_____

□ Other (e.g., x-rays, bills), specify, including date(s):_____

□ Summary or explanation of PHI requested:_____

You may use or disclose the following health care information regarding testing, diagnosis, and treatment, should it be found in my records, only if checked below:

□ HIV (AIDS Virus)

□ Reproductive Health records

□ Psychiatric disorders/ mental health records

□ Drug and/or Alcohol use/ substance Use disorder

□ Sexually transmitted diseases/ communicable diseases

You may disclose this health care information to: □ Self □ 3rd Party/Organization/Individual

Via □ paper format □ electronic format

If to self:

□I want my records physically mailed to me at (include full address):

Address:_____

City: _____State:_____

Zip: _____

□ I will pick up my records from the practice facility when they are ready

If to 3rd Party/Organization/Individual:

Name (or title) and Organization to receive records:_____

□ Mailed to:

Address:_____

City: _____ State: _____ Zip: _____

□ E-mailed to: _____

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.

Reason(s) for this authorization (check all that apply):

□ Healthcare □ Research □ Marketing/Sale □ Legal

□ Other (please specify): _____

This authorization ends:

□ On Date: _____

□ When the following event occurs: _____

□ In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment.)

2. My Rights

I understand that I do not have to sign this authorization or waive any rights under the Privacy Rule and that my healthcare treatment, payment, enrollment or eligibility for health plan benefits will not be affected if I do not sign this authorization. However, I do have to sign an authorization form to:

- Take part in a research study or
- Receive health care when the purpose is to create health care information for a third party

I understand that I have the right to revoke this authorization at any time, by notifying the physician in writing. I also understand that a written revocation is not effective for any actions already taken by the physician and staff based upon this authorization. I understand that the information used or disclosed may be subject to re-disclosure by the person or organization that receives it and would then no longer be protected by federal privacy regulations.

I understand that I may be charged limited reasonable fees associated with this request for labor, supplies and postage, except for access to PHI that is available through my provider's EHR (Electronic Health Record system) or when I inspect my PHI at the facility. Any fees assessed for my request will be communicated with me as soon as possible, and arrangements will be made with the practice for the payment of any fees assessed and for the delivery or pickup of the requested records.

I understand that the practice is required to provide me with a response to my request within 30 days, with one 30 day extension (when justified).

_____

Patient or legally authorized individual signature Date &Time

_____

Print name if on behalf of the patient Relationship with patient (parent, legal guardian, personal representative)