Delaware Eye
INSTITUTE
18791 John J. Williams Hwy, Rehoboth Beach, DE 19971 · Ph: 302-645-2300 · Fax: 302-645-2355

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE FORM

Patient name: _____ Date of Birth: _____

Phone: _____ Address: _____

Previous name(s): _____ Medical Record Number: _____

I. Authorization

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

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the dates(s): _____
- ☐ Other (e.g., x rays, bills), specify date(s): _____

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)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

- ☐ Self: Pick Up
- ☐ Mail to address above

Name (or title) and organization : _____

Address (optional): _____ City: _____ State: ____ Zip: _____

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

- ☐ At my request
- ☐ Other (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)

II. My Rights

I understand I do not have to sign this authorization or waive any rights under the Privacy Rule in order to get health care treatment, payment, enrollment or eligibility for benefits. However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing by notifying the physician. If I did, it would not affect any actions already taken by the physician 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.

_____ _____

Patient or legally authorized individual signature — Date — Time

_____ _____

Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative)

***This form is to be used only for releasing Delaware Eye Institute records to a patient or another facility.**