Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand St. Lucy's Eye surgery Center is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of St. Lucy's Eye Surgery Center, or any other individual listed below to disclose my protected health information as described on this forma to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used to disclosed (*Check all that apply*):

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

[ ] The patient's demographic information (*Check all that apply*):
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other: _____

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:

_____

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:

_____
_____
_____

Purpose(s) of the information:

_____

_____

[ ] (*Check if applicable*) This authorization is to be used for our own use, and St. Lucy's Eye Surgery Center will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used to disclosed and may refuse to sign this authorization.

[ ] (*Check if applicable*) The patient understands that St. Lucy's Eye Surgery Center may receive financial gain as a result of disclosing this information due to

_____
_____.

[ ] (*Check if applicable*) This authorization permits St. Lucy's Eye Surgery Center to send the protected health information ONLY to this address or fax number:

_____
_____
Any other address or fax number is not permitted by this authorization.

The patient had a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, St. Lucy's Eye Surgery Center must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The Date of the revocation, and the patient's signature.

St. Lucy's Eye Surgery Center will accept written revocations of this authorization via:
[ ] Certified U.S. mail
[ ] Facsimile at this number: 239-481-7898

ALL revocations must be sent to St. Lucy's Eye surgery Center to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, St. Lucy's Eye Surgery Center can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient Signature Date

_____
FOR OFFICE USE ONLY
Authorization added to the patient's medical record on _____.

Authorization verified by _____________________ on ____________________________.

In-Person Request for Protected Health Information

Before St. Lucy's Eye Surgery Center can complete your request for protected health information, we must first verify and document your identity, the information you would like to use or disclose, and your purpose(s) in requesting this information. You understand that if you request protected health information from a patient without his or her authorization, we may refuse to provide you access to this information.

Please fill out the information below. Be as accurate and specific as possible.

Date: _____ Time: _____

Person Requesting Information

Name: _____
Business: _____
Address: _____ Home Tel: _____
_____ Work Tel: _____

Relationship to patient (check one):

[ ] Spouse [ ] Parent [ ] Child [ ] Grandparent [ ] Grandchild
[ ] Aunt or Uncle [ ] Attorney (or representative) of patient [ ] Legal Guardian
[ ] Other: _____

Information Requested:

Name/Class of Patient(s): _____
_____

I am requesting the following protected health information:
_____
_____
_____
_____

The purpose(s) of my obtaining this information is (*check all that apply)*:
[ ] Treatment of the patient [ ] Payment [ ] Health care operations [ ] Other

Please explain: _____
_____
_____
_____

Note: I understand the “minimum necessary” rules may apply, and I may not receive all the requested information.

Please check all that apply.

[ ] I have a valid authorization from the patient to use and disclose this information not on file at this organization, and I have attached it to this form.

[ ] This information is covered by a previous authorization dated _____, and this authorization had not expired by been revoked by the patient.

[ ] I do not have an authorization from the patient(s). Please send your standard authorization form to your patient(s) for their signature and approval.

I certify that the information on this request form is true and accurate to the best of my knowledge, and I shall not use or disclose the information received from St. Lucy's Eye Surgery Center for any purpose other than listed on this form. I further understand I am bound by the terms of this form and the accompanying authorization (if applicable) until such time that I return the information to St. Lucy's Eye Surgery Center or destroy all copies of the information in my possession.

_____
Signature of Person Requesting PHI

FOR OFFICE USE ONLY

Verified identity using: [ ] Driver’s License [ ] Work/Gov’t ID
[ ] Company/Agency letter [ ] Other:_____

Verified authority to request information using:
[ ] Patient’s current authorization [ ] Written authority on agency letterhead
[ ] Judicial subpoena/court document [ ] Other: _____

Number of patient records included in this request: _____.

Request entered in logbook on _____ at page _____.

[ ] Request approved by _____ on _____.

[ ] Information sent to recipient via _____ on _____.

Request for Correction/Amendment of Health Information

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Privacy Officer.

Patient Name: _____ Birth date: _____

Patient Number: _____

Patient Address: _____
_____
_____

Date of amendment request: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____
_____
_____
_____
_____
_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address:

_____
_____
_____

Name/Address:

_____
_____
_____

I understand that by listing the name(s) and address(es) of other organizations on this Amendment form, I am asking St. Lucy's Eye Surgery Center to disclose the requested amendment to these organizations. I therefore, give specific permission to St. Lucy's Eye Surgery Center to disclose the amendment to these organizations, and I understand that St. Lucy's Eye Surgery Center will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand St. Lucy's Eye Surgery Center may be required to send this amendment to Business Associates or other organizations that St. Lucy's Eye Surgery

Center identifies as needing the amendment. I therefore, give specific permission to St. Lucy's Eye Surgery Center to send the requested amendment to these organizations identified by St. Lucy's Eye Surgery Center as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be not longer available to act on this amendment request, and present to St. Lucy's Eye surgery Center evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, St. Lucy's Eye Surgery Center may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

_____

Signature of Patient

_____

Date