Authorization for Use or Disclosure of Protected Health Information

I have been offered and reviewed a copy of the Eyecare Associates Notice of Privacy Practices. By completing this form, I authorize my physician and/or administrative staff of Eyecare Associates to disclose general medical information and other protected health information to the following person(s) and/or entities listed below. If no one is listed below, protected health information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) to whom you elect to allow access – for example, your spouse, child, parents, neighbor, caretaker, close friend:

Name of Person or Entity	**Relationship**

This authorization to use and disclose the protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Eyecare Associates and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy contact at 4324 Veterans Blvd, Metairie, LA 70006. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was given as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

My physician will not condition my treatment, payment or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

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Description of Personal Representative's Authority