AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Medina Vision & Laser Centre
4463 Weymouth Road, Medina, OH 44256

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medina Vision & Laser Centre may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and/or disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

I, ____ (print name) hereby authorize the use and/or disclosure(s) of the following protected health information that pertains to me:

Personal and family medical and ocular history
Ocular health function
Prescription information

I authorize the use and/or disclosure (s) of the above protected health information for the following purpose(s):

Ocular related entities such as:
Referral or consultation with another health care provider
Insurance authorization and billing
School nurse, family physician, or teacher summaries

I authorize the following person(s) and/or entity(ies) to use and/or disclose my protected health information:

Medina Vision and Laser Centre, Inc. and its subsidiary companies and its employees

I authorize the following person(s) and/or entity(ies) to receive my protected health information:

Ocular related entities such as:
Referral or consultation with another health care provider
Insurance authorization and billing
School nurse, family physician, or teacher summaries

I understand that the protected health information used and/or disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by notifying Medina Vision & Laser Centre at 4463 Weymouth Road, Medina, Ohio 44256 in writing. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any protected health information disclosed pursuant to this authorization.

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE SEVEN YEARS AFTER THE DATE OF AUTHORIZATION

Print Name: ____

Signature: ____ Date: _______________

Date of Birth: _________________________ S.S. #: ________________________________

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

Nature of Relationship: ____

Signature: ____ Date: ____________