Center for Sight, Inc.

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

___________________________________ ____

Patient Name Guardian or Authorized Party Name (if applicable)

___________________________________ _________________________________

Social Security Number Date of Birth

The purpose of this disclosure is:

1. _________ Medical Care
2. _________ Insurance Purposes
3. _________ Other (please specify)____

I authorize the use and disclosure of my health information as described below:

Information Requested:

______ Records relating to treatment dates from: ____________________ to_________________________

______ Records for all care at this facility or by this doctor (See below for Fee Schedule)

______ Dictated summary of medical records (No charge)

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released [ ] from [ ] to ____

____

____

[ ] from [ ] to Center for Sight, Inc.
1565 North Main Street – Suite 406
Fall River, MA 02720
Tel: (508) 730-2020 Fax: (508) 675-2020

_____ (**Initials of patient or guardian**) I understand that Center for Sight Inc., may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

____ ______________________

Signature of Patient or Guardian** Date

A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions and HIV information, I DO________ DO NOT________ authorize the release of this information.

**If this authorization is signed by an individual's personal representative, the representative's authority is based on:
____(e.g. state law, court order, etc.)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. Our fee is currently $25.00 for handling and $.10 per page for copies. This amount is less than what is allowed by law. (243 C.M.R. 2.07 (13))

For office use only:

Physician Authorization: _____________________ Date Sent: _________________________ By: _____________