envision
OPHTHALMOLOGY & WELLNESS

Release of Information Form

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

My Authorization

I authorize the following using or disclosing party: _____

To use or disclose the following information:

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition:
- ☐ My health information covering the period of healthcare from (please specify dates)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

Envision Ophthalmology & Wellness

6551 Wilson Mills Road, Suite 103

Mayfield Village, OH 44143

P: (440) 291-3051

F: (440) 597-4382

This authorization ends:

- ☐ Until revoked in writing
- ☐ On (date)
- ☐ When the following event occurs:

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it if requested. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____