VITREO-RETINAL ASSOCIATES, PC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ **DOB:** _____

Persons/Organizations *providing* information:

_____
_____
_____

Persons/Organizations *receiving* information:

_____
_____
_____

Specific description of information requested, including dates (if relevant):

_____
_____

Description of each purpose of authorized use or disclosure:

_____
_____

("At the request of [patient's name]" is sufficient when patient initiates authorization and elects not to provide a more detailed statement of purpose).

Expiration Date:

This authorization will expire on ___/___/___ (MM/DD/YR) or on the occurrence of the following event:

_____

Revocation:

This authorization may be revoked at any time by notifying, *in writing*, to Vitreo-Retinal Associates, PC at 67 Belmont Street, Suite 302, Worcester, MA 01605. If I revoke this authorization, I understand that it will not have any effect on actions Vitreo-Retinal Associates, PC took before it received the revocation.

Section B: Must be completed if health care provider or health plan requested the authorization and/or authorization is for research:

1. Health care provider or health plan must complete the following:
   a. Will provider or health plan receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ___ Yes _X__No
2. Patient must complete the following:
   a. I understand that I may see and copy the information described on this form if I request to do so, as well as a copy of this form after I sign it. Initials _____
   b. I understand that, in most situations, my health care provider will treat me regardless of whether I sign this authorization. If the purpose of the authorization is to allow research-related treatment, I understand I will not be able to get that treatment without signing this form. Initials _____
   c. I understand that a health plan may condition enrollment or eligibility for benefits on my authorization releasing requested medical records other than psychotherapy notes prior to my enrollment in the plan. However, once I am enrolled, the plan may not refuse to pay for my care, adjust my eligibility for benefits or remove me from the plan if I refuse to sign an authorization. Initials_____

If signed/authorized by Legal Representative:

By my signature below, I confirm that I have legal authorization to sign such legal documents as this on behalf of the patient and understand that I *must provide documentation proving my authorization prior to the release of the patient's information.*

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Printed Name of Legal Representative Relationship to Patient

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION - Questions? Call our office at (508) 752-1155**