Phone (231) 739.9009 Fax (231) 733.0566

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize (Name) _____,

(Address) _____,

(Phone) _____ (Fax) _____ to use/or

disclose protected health information (PHI) for _____ to:

_____ Shoreline Vision, 1266 E. Sherman Blvd. Muskegon, Michigan 49444

_____ Self

_____ Family Member _____ Relationship: _____

_____ Practice: _____ Address: _____

Phone: _____ Fax: _____

This authorization permits _____ to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____ All Records _____ Dates from _____/_____/_____ to _____/_____/_____

_____ Records pertaining to _____ diagnosis

_____ Specific Information: _____

_____

The information will be used or disclosed for the following purpose: _____

_____.

If requested by the patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow

release of the information. This authorization will expire on _____
{Expiration Date or Defined Event}.

Shoreline Ophthalmology will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Shoreline Ophthalmology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Shoreline Ophthalmology has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

1266 East Sherman Blvd.

Muskegon Michigan 49444

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Patient Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION