Disclosure of Health Information

I give my authorization to use or disclose my protected health care information as described below: I give this authorization voluntarily.

Patient name: _____

Date of birth:_____

Previous name(s):_____

Patient address:_____

Patient phone number: _____

1. My authorization:

You may disclose all the following healthcare information (check all that apply):

- ☐ All my health information
- ☐ Eye Operation Notes (dates_____)
- ☐ My health information relating to the following treatment for condition(s):

_____

- ☐ My health information for the dates:_____
- ☐ Other:_____

2. You may disclose this health information to:

Alaska Children's Eye & Strabismus

3500 Latouche Street Suite 280, Anchorage, AK 99508

–or –

Name:_____

Address: _____

City:_____ State:_____ zip:_____

3. Reason for this authorization:

- ☐ At my request
- ☐ Other (specify):

4. Authorization will end on the following date: _____

5. Changing your mind about this authorization:

I understand that I may revoke this authorization at any time by giving written notice. How are however, I understand that I may not revoke this authorization for any actions taken before receipt of my notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

6. Signing this authorization is not a condition of treatment:

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However I understand that signing an authorization that permits the use and or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research related treatment. Also I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for the disclosure to a third-party. And under some circumstances, health plan may condition my enrollment in a health plan or for my my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations

7. Individual patient's signature

I agree to pay reasonable copying costs of $25 for one complete copy of my record. I understand that it may take up to 30 days to receive my copy from the day the request was made. Alaska Children's EYE & Strabismus will make every effort to process process my copy in a timely manner

I have had a chance to read the content of this authorization form and I agree with all statements made in this authorization.

Once the office discloses health information the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ Date:_____

(signature of parent of legally authorized individual)

_____ _____

(printed name if signed on behalf of patient) (Relationship- parent/legal guardian)