AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, DOB _____ authorize Gadsden Eye Associates, P.C.,

Dr._____ and/or administrative and clinical staff to (check all that apply):

_____ use the following protected health information, and/or

_____ disclose the following protected health information to the following entity or person:

_____
_____
_____
_____

The information to be disclosed is as follows (check all that apply):

_____ medical records
_____ financial records
_____ other (describe) _____

This information is being used or disclosed for the following purpose:

_____
_____

This authorization shall be in force and effect until _____ (date or event), at which time this authorization to use or disclose this protected health information will expire.

I understand that I have the right to revoke this authorization, by written notice at any time by sending such written notification to the Privacy Contact at 429 South 3rd Street, Gadsden, AL 35901. I understand that a revocation is not effective to the extent that my physician or his/her staff has relied upon the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient to whom the information is released, and may no longer be protected by federal or state law.

My physician will not condition my treatment on whether I provide authorization for the requested use or disclosure except if (1) my treatment is related to research; or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____
SIGNATURE OF PATIENT, PERSONAL REPRESENTATIVE OR GUARDIAN

_____
PRINT NAME

_____
DATE