UNIVERSITY OPHTHALMOLOGY ASSOCIATES INC.
1611 South Green Road, Suite 306-C
Cleveland, Ohio 44121-4128
(216)382-8022
FAX (216) 382-7667

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION TO BE RELEASED TO UNIVERSITY OPHTHALMOLOGY ASSOCIATES

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Patients printed name: Address:

_____ _____ _____
Date of Birth: Social Security Number: Univ Ophthalmology: Number:

Specific description of the information to be used or disclosed, including the specific purpose:
_____
_____
_____

Individuals who may use or disclose this information:_____

_____

_____

Individuals who may receive and use the disclosed information: _____
Physician's Name

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Expiration date of this authorization: _____

By signing this form, you authorize the Discloser to disclose protected health information about you for the reasons mentioned above. You .have the right to revoke this authorization at any time, -in writing, signed by you. However, such a revocation shall not·affect any disclosures that have already made in reliance on your prior authorization.

Signature: _____ 'Printed Name: _____
Person giving consent Person giving consent

Relationship to Patient. _____Date: _____/_____/_____
other than patient):

Signed In front of _____OR_____
Printed name - Practice representative Witness Signature