The Retina Care Center, LLC
Authorization for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the HIPAA Privacy Standards.

Patient Name: _____ DOB: _____

Use or disclose the following health information:

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information covering the period of healthcare from (date) _____ to (date) _____
- ☐ Other: _____

The Retina Care Center may disclose this health information to the following recipient:

Name	Phone
Street Address	Fax
City, State, ZIP Code	

The purpose of this authorization is (check all that apply):

- ☐ At my request
- ☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ☐ Other: _____

This authorization will expire in 180 days from the date of signing or:

☐ (date) _____ ☐ End of research study

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing as set forth in the Notice of Privacy Practices.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA rules.
- I understand that this authorization is voluntary and I may refuse to sign this authorization without affecting my health care or the payment for my health care.
- I have the right to request a signed copy of this form, as well as inspect or copy any information to be used and/or disclosed under this authorization.
- I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **I ☐ consent / ☐ do not consent to have this information released.**

I hereby authorize The Retina Care Center, LLC to use and/or disclose my protected health information (PHI) as described above.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient

OFFICE USE ONLY

Authorization obtained by: _____

(Use this form ONLY for request of records from RCC, marketing purposes, and sale of PHI.)