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Wasatch View Eye Care
Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth:_____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):_____

☐ Other:_____

You may disclose this health information to:

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Phone: (_____) _____ Fax: (_____) _____

This authorization ends: ☐ on (date) _____

☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

or

- To provide health information to a desired third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization:

- Write a letter to the office.

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

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)