EYE WELLNESS CENTER / BELLAIRE EYE CARE **OFFICE: 713-592-6550**
WWW.EYEWELLNESSCENTER.COM **FAX: 713-942-0265**

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION AND PATIENT ACCESS

I. PATIENT INFORMATION:

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: XXX – XX – XXXX

PATIENT MAILING ADDRESS (LINE 1): _____

PATIENT MAILING ADDRESS (LINE 2): _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

II. INFORMATION TO BE USED OR DISCLOSED:

FOR DATE(S) OF SERVICE: _____

[ ] ENTIRE RECORD [ ] OUTPATIENT CLINIC RECORD [ ] BILLING RECORD

[ ] FILMS [ ] PICTURES [ ] OTHER: _____

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION FORM MAY INCLUDE INFORMATION RELATING TO HUMAN IMMUNODEFICIENCY VIRUS (HIV), OR AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS); TREATMENT FOR OR HISTORY OF DRUG OR ALCOHOL ABUSE; OR MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE.

III. INFORMATION TO BE USED OR DISCLOSED TO:

NAME OF RECIPIENT: **MAILING ADDRESS ONLY!**

EYE WELLNESS CENTER / BELLAIRE EYE CARE
2726 BISSONNET ST. SUITE #240-54
HOUSTON, TEXAS 77005

TELEPHONE: 713 592-6550
FAX: 713 942-0265

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION AS DESCRIBED ABOVE. I UNDERSTAND:

- THIS AUTHORIZATION IS VALID FOR 180 DAYS UNLESS OTHERWISE STATED HERE: _____
- A PHOTOCOPY OR FAX OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A REVOCATION IN WRITING TO THE RECIPIENT ABOVE.
- IF I REVOKE THIS AUTHORIZATION, THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN GOOD FAITH ACCORDING TO THIS DISCLOSURE BEFORE THE REVOCATION WAS RECEIVED.
- TREATMENT OR PAYMENT MAY NOT BE CONDITIONED ON MY COMPLETION OF THIS AUTHORIZATION FORM.
- IF THE RECIPIENT INDENTIFIED ABOVE IS NOT COVERED BY FEDERAL OR TEXAS PRIVACY LAWS, THE INFORMATION MAY NOT BE PROTECTED UNDER THESE LAWS ONCE IT IS DISCLOSED TO THE RECIPIENT AND MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT.
- I MAY BE ASKED TO PROVIDE PROOF OF MY IDENTITY/GUARDIANSHIP WITH THIS AUTHORIZATION.
- FEES/CHARGES WILL COMPLY WITH ALL LAWS AND REGULATIONS APPLICABLE TO RELEASE OF PROTECTED HEALTH INFORMATION. PAYMENT IS DUE AT THE TIME OF RELEASE OF INFORMATION.

_____

SIGNATURE OF PATIENT OR QUALIFIED PERSONAL REPRESENTATIVE * **DATE**

*IF SIGNED BY A QUALIFIED PERSONAL REPRESENTATIVE, THE FOLLOWING MUST BE COMPLETED:

PRINTED NAME OF QUALIFIED PERSONAL REPRESENTATIVE: _____

LEGAL DOCUMENTATION SHOWING AUTHORITY TO ACT OF BEHALF OF THE PATIENT:

(EXAMPLE: GUARDIAN OF PATIENT, EXECUTOR OF ESTATE): _____

FOR INTERNAL USE ONLY

_____

VERIFICATION OF SIGNATURE/AUTHORITY DATE

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