AFFILIATED EYE SURGEONS, LTD

DIPLOMATES AMERICAN BOARD OF OPHTHALMOLOGY

Raymond Zimmerman, MD   James Koster, MD   E. Fredrick Bloemker, MD

CONFIDENTIAL Authorization to Disclose Protected Health Information

In order to provide for your healthcare, our practice collects information about your medical history, physical examinations, test results, diagnosis and treatments. Use and disclosure of Protected Health Information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes which may or may not relate to your treatment, receiving payment or healthcare operations. This authorization gives Affiliated Eye Surgeons permission to disclose the elements of your protected health information to the stated recipient.

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I understand that I may revoke this authorization in writing at any time. However, I further understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information.

Therefore I (print), ____

DOB: ______________________ Soc Sec #: ______________________

Address: ____

Consent to the disclosure of the following information:

O Full medical record   O Other (please specify): ______________

I hereby give special permission to release otherwise privileged information pertaining to:

O Mental Health   O AIDS test results
O Developmental disabilities   O AIDS related disease diagnosis
O Alcoholism   O Drug abuse

Release To: Name ____

Address ____

Phone # ______________ Fax # ______________

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Patient (signature)   **Date**

____

Records prepared by: O Mailed ______   O Faxed ______   Physician approval: ______   Privacy Officer: ______