Authorization for the Use or Disclosure of Protected Health Information

Eldred Eye Center Of Cheyenne

2029 Bluegrass Circle

Cheyenne, WY 82009

307-638-2020

AUTHORIZATION SECTION

I, ____

DOB _________________ hereby authorize the (use/disclosure/use and disclosure) of the following health information that pertains to me.

All of my health information

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. This authorization expires 1 year after date of signature or when revoked in writing.

Signature____

__________________________ Date

As Required by the Health Insurance Portability and Accountability Act of 1996, Eldred Eye Center of Cheyenne, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization in writing, at any time, except where uses or disclosures have already been made based upon your original permission.