NORTH BAY EYE ASSOCIATES, INC.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NBEA provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient name: ____

Date of birth: ______________________________ ACCT #: __________________________

I. My Authorization:

I authorize:

Name (or title) and organization____

Address: _________________________________ _ City ______________________________

State _________Zip_______

to use or disclose the protected health information described below to:

Name (or title) and organization____

Address: _________________________________ _ City ______________________________

State _________Zip_______

II. Effective Period:

This authorization for release of information covers the period of healthcare from:

a. ☐ ________________ to _____________

OR

b. ☐ all past, present, and future periods.

III. Extent of Authorization:

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.)

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐Mental health records

☐Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug treatment

☐ Other (please specify): ____

V. My Rights:

- I understand I have the right to revoke this authorization at any time, in writing, sent to North Bay Eye Associates, Inc., Attn: Privacy Officer, 50 Professional Center Dr., Suite # 210, Rohnert Park, CA 94928. If I do, it will not affect any actions already taken by North Bay Eye Associates, Inc. based upon this authorization; uses and disclosures already made cannot be taken back;
- Once the office discloses health information, the person or organization that receives it may re-disclose it and it may no longer be protected;
- I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:
  - To take part in a research study; or
  - To receive health care when the purpose is to create health information for a third party
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signed by Patient: ____ Date: ___________

Or

Signed by Personal Representative:

____ Date: ___________

On Behalf of:

____

Name of Patient

Personal Representative Information:

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER: ____________________