CLARENDON VISION DEVELOPMENT CENTER

760 Pasquinelli Drive, Suite 300
Westmont, IL 60559
P: 630-323-7300 F: 630-323-7662

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient (or Minor): _____ Date:_____

Date of Birth: _____ Last four SSN #: _____

I. My Authorization

I authorize Name (or title) and organization:
_____

Address _____

City _____ State _____ Zip Code:_____

Phone Number: _____ Fax Number: _____

To disclose the following health information: *(check one)*

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

☐ - Other: _____

The above party may disclose this health information to the following recipient:

Clarendon Vision Development Center
760 Pasquinelli Drive, Suite 300, Westmont IL 60559.
Phone: 630-323-7300 Fax: 630-323-7662, info@clarendonvision.com

The purpose of this authorization is: *(check all that apply)*

☐ - At my request

☐ - To collaborate with my treatment.

☐ - Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

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I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Authorized Representative:_____ Date: _____

Print Name of Authorized Representative: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age
☐ - Patient is unable to sign because: _____

Authority of representative to sign on behalf of the patient:
☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____