OPTOMEDICA EYE CONSULTANTS
2430 North Fry Road, Suite 108
Houston, Texas 77084

HIPPA Privacy Authorization for Use and Disclosure
Personal Health Information

This Authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq, and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPPAA"). This Authorization affects your rights related to the privacy of your personal health care information, Please read it carefully before signing.

Optomedica Eye Consultants " Covered Entity" will not condition treatment, enrollment in a health plan, or eligibility date for benefits, as applicable, on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. By signing this authorization you agree that Covered Entity or its Business Associates may disclosure your personal health care information to Cole Managed Vision, Medicare, Medicaid, or _____ (Identify intended recipients).

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPPA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPPA. While Covered Entity has reserved the right to change the terms of its Privacy Notices, as amended, are available from Covered Entity at its office or by sending a written request with a return address to Optomedica Eye Consultants, 2430 North Fry Rd, Ste. 108. Houston, Tx 77084.

In accordance with your rights under, and subject to, certain restrictions imposed by HIPPA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoke at the address listed above.

This authorization shall expire upon the earliest occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services; Office of Civil Rights, that this authorization is not in compliance with requirements of HIPPA; © complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six year from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPPA.

Covered Entity will provide _____ [name of patient] with a copy of this signed authorization.

Acknowledge and agreed to by:

_____ _____
Signature Date
Signature of Patient or On Behalf of Patient Date