Eastern Sierra Eyecare

Raymond J Ruckman OD
& Associates

111 West Tenth Street, Carson City, NV 89703
Phone: 775-883-4664 - Fax: 775-883-4750

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Patient's Date of Birth** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   _____
   His/her/its Name

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____
   NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Eastern Sierra Eyecare in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for personal healthcare needs.
7. This authorization expires **One Year** from signing form, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____ _____ _____
Signature of Individual* **Date of Individual's Signature** **Date of Birth or Social Security Number**
(The person about whom the information relates)

OR, if applicable –

_____
Signature of Guardian

A copy of this completed, signed and dated form must be given to the Individual or other signator.

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