HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how North Pole Eyecare may use and disclose your protected health information and when we need your written authorization to do so. This form complies with the HIPAA Privacy Standards and 42 CFR Part 2.

Name of Patient (print): _____ Date of Birth: _____

I. My Authorization

I authorize **North Pole Eyecare** to use or disclose the following health information:

- ❑ I authorize the use or disclosure of my records, including any Substance Use Disorder (SUD) records, for all current and future Treatment, Payment, and Health Care Operations (TPO) as permitted by law.
- ❑ All of my health information
- ❑ Specific treatment or condition: _____.
- ❑ Specific date range: From _____ (Start Date) to _____ (End Date).

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

Name/Organization: _____

Phone: _____ Fax: _____ Email: _____

II. State Law and Sensitive Information

In some cases, state or other federal laws provide greater privacy protections for specific types of "sensitive" health information. I understand that I may choose not to initial any of the categories below, and my refusal to sign will not affect my ability to receive treatment (unless the authorization is specifically required for research-related care or to create information for a third party).

By initialing below, I specifically authorize the release of information related to:

- _____Reproductive Health (Abortion/Contraception)
- _____Infectious Disease (HIV/AIDS testing/treatment)
- _____Mental Health: (Treatment/Genetic Testing)
- _____Substance Use Disorder (SUD Records)

Note: When stricter laws apply, we follow the law providing you with the most protection.

III. Purpose of This Authorization

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

- ❑ At my request.
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

❑ Other: _____

IV. Legal Protections and My Rights

- Legal Proceedings Prohibition: Records received from programs subject to 42 CFR Part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against me without my specific written consent or a court order.
- Right to Revoke: I may revoke this authorization in writing at any time, except where disclosures have already been made based on my original permission.
- Redisclosure: Information disclosed with my permission may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.
- SUD Counseling Notes: A separate, standalone consent is required for the release of any SUD Counseling Notes (kept separate from the medical record).
- 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.

V. Expiration and Revocation

This authorization remains in effect until the following date or event:

❑ On (Date): _____
❑ When I am no longer a patient of the practice.
❑ Other: _____.

VI.Signatures and Acknowledgements

By signing below, I acknowledge the following:

1. Authorization: I authorize the release of all information checked in Sections I, II, and III.
2. Rights: I understand my right to revoke this in writing and the prohibition of use in legal proceedings.
3. Condition of Care: My treatment is not conditioned upon signing this authorization.
4. Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices and have read and understood its content.

Patient Name (print): _____ Date of Birth: _____

Signature (Self/Parent/Guardian): _____ Date: _____ ***(If signed***

by a Representative, state authority: _____).