Wiles Eye Center

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you and pursuant to our general Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Individuals who may use or disclose this information: **Wiles Eye Center**.

Individuals who may receive and use the disclosed information: _____

If yes what Phone Number would you like our office to use _____

Please circle if you give authorization for our office to leave a message regarding the above information. ↑
Yes No

Expiration date of the authorization (**if needed**): DATE: ___/___/_____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer or the Practice.

Patient or Patient Representative Signature: _____

Printed Name of Patient or Representative:_____

Patient's Date of Birth _____ Date:_____

Patient's Name if minor: _____