

Eye Clinic of Meridian, PLLC

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Eye Clinic of Meridian • Butler Eye Center • Livingston Eye Center • Meridian Eyecare

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the Eye Clinic of Meridian, PLLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Eye Clinic of Meridian, PLLC.

Name and relationship of person who you wish to allow access - for example, your spouse, sibling, neighbor, care-taker, close friend:

Name of Person or Entity	Phone #	Relationship
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This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Eye Clinic of Meridian, PLLC and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such a written notification to the practice's Privacy Contact. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative _____

Date _____

Print Name of Patient or Personal Representative _____

Description of Personal Representative's Authority _____

