the eye clinic
surgicenter | 2475 Village Lane. Billings, MT. 59102 T: (406) 252.6608 F: (406)252.6600

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize

[ ] The Eye Clinic/Surgicenter
[ ] Other organization or individual

_____
(name and address of person/organization that may disclose your protected health information)

To use and/or disclose my private health care information as described below to:

Name: _____
(name of person or organization to whom your protected health information may be disclosed)
Address: _____
City: _____ State: _____ Zip: _____

The type of information to be used or disclosed is as follows:

[ ] All medical records
[ ] Diagnostic tests
[ ] Operative reports
[ ] Consultation reports
[ ] History and Physical
[ ] Other _____

This information is needed for the purpose of:

[ ] Continued Care
[ ] Self
[ ] 3RD Party
[ ] Other _____
[ ] Insurance Verification
[ ] Disability Services
[ ] Dissatisfied Dr. / Staff

I understand that if the person/entity receiving this information is not a health plan or health care provider covered by federal privacy rules, that the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I also understand that I may revoke this authorization at any time by notifying The Eye Clinic/SurgiCenter in writing and that my revocation will not affect any actions taken by The Eye Clinic/SurgiCenter prior to receiving my revocation.

Authorization expires: _____
(you may write "not applicable" if the authorization does not expire)

_____ _____
Signature of patient or legal representative Date

_____ _____
If signed by legal representative, relationship to patient Witness signature

_____ _____ _____
Patient's printed name Patient's SSN Patient's date of birth