NORTHERN OHIO EYE CENTER, INC.
6355 Pearl Rd. Parma Hts., OH 44130 440-886-2020

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

______________________________ Patient Name

______________________________ Guardian or Authorized Party Name (if applicable)

______________________________ Social Security Number

______________________________ Date of Birth

I authorize the use and disclosure of my health information as described below:

Information Requested:

_____ Records relating to treatment dates from: ________________ to ________________

_____ Records for all care at this facility or by this doctor.

_____ Other (Please specify) ____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by laws has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released ___from ___ to ______________________________________

Address: ______________________________________

____

FAX # ______________________________________

___from ___to **Northern Ohio Eye Center, Inc.**
Stanley F. Pajka, M.D.
6355 Pearl Rd.
Parma Hts., OH 44130
Phone 440-886-2020 Fax 440-886-2779

________ **(Initials of patient or guardian)** I understand that Northern Ohio Eye Center, Inc. may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

______________________________ Signature of Patient or Guardian**

______________________ Date

A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse, or psychological/psychiatric conditions, I DO _____ DO NOT ______ authorize the release of information.

**If this authorization is signed by an individual's personal representative, the representative's authority is base on: ____________________________________ (e.g., state law, court order, POA, etc)

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $1.00 per page for the first 25 pages and $0.25 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

FOR OFFICE USE ONLY: Physician authorization______________ Date sent_________ By__________