Eye Surgery Associates

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

_____ 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 law has the right to contest a claim or the insurance policy. I understand that the uses and disclosures already made based upon my original permission cannot be taken 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 _____

_____

_____

[ ] from [ ] to Eye Surgery Associates

_____ Akintomide Apara, M.D.
_____ Joel Sandberg, M.D., F.A.C.S.
_____ Arthur Fishman, M.D., F.A.C.S.
_____ Mark Dorfman, M.D., F.A.C.S., F.A.A.P.
_____ Jacquelyn Daubert, M.D.
_____ Gabriella Rifkin, M.D., J.D.

_____ Albert Caruana, M.D
_____ Guy Angella, M.D., F.A.C.S
_____ Scott Cardone, M.D.
_____ David T. Jones, M.D., Ph.D.
_____ Cristina Fernandez, M.D.
_____ Michael L. Glassman, M.D., F.A.C.S.
_____ Kenneth Adams D.O, J.D., F.A.O.C.O

——— 300 South Park Rd, Suite 300, Hollywood, Fl 33021● 954-925-2740 ● Fax: 954-342-0028
——— 603 N. Flamingo Rd., Suite 250, Pembroke Pines, Fl 33028 ● 954-431-2777 ● Fax: 954-431-1856
——— 2300 N. Commerce Pkwy, Suite 307, Weston, Fl 33326 ● 954-217-3155 ● Fax: 954-217-3156

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

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records.
This fee is $1.00 for the first 25 pages and $0.25 for each page thereafter .***Please allow a minimum of 7-10 business days to process your request.***

For office use only:
Physician Authorization _____ Date Sent: _____ By: _____