SALUS UNIVERSITY
The Eye Institute

AUTHORIZATION
FOR USE & DISCLOSURE OF HEALTH INFORMATION

Medical Records Department Fax: 215.276.6096

I _____ ,with a date of birth of _____, hereby authorize The Eye Institute of Salus University ("Provider") to use and release my Health Information, as designated below, to:

Recipient: _____

Recipient Address: _____

_____

Recipient Telephone Number: _____

Recipient Fax Number: _____

The following Health Information about me may be used and disclosed (*check each either "Yes" or "No/NA"*):

	Yes	No *or* N/A
My entire medical or billing record	☐	☐
A specific date range: from _____ to: _____	☐	☐
Only the following elements of the record (e.g., photos, prescriptions, test results, etc.): _____	☐	☐
Other: _____	☐	☐

The Health Information checked "yes" above may be used for the following Purpose(s):

☐ At my request, or
☐ For the Purpose of: _____

_____ (Initial) By initialing here, I also specifically authorize my Health Information to be used and disclosed by Provider for Marketing purposes.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), as may be amended from time to time. I understand that I have the right to revoke this Authorization, at any time prior to Provider's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Provider's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature and that I should send it to: The Eye Institute, Attn: Privacy Officer, 1200 West Godfrey Avenue, Philadelphia, PA 19141-3323.

I understand that I am not required to sign this Authorization and that Provider may not condition treatment on my execution of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This Authorization expires automatically upon Provider's release of my Health Information as needed to fully accomplish the above-described Purpose(s). I hereby acknowledge receipt of a copy of this Authorization.

_____ / _____ / _____ Date

_____ Signature of Individual (or Legal Representative)

_____ Legal Rep's Authority

_____ Printed Name of Individual (or Legal Representative)