VALLEY EYE SPECIALISTS AND
VALLEY OUTPATIENT SURGICAL CENTER
AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provide information about how we may use and disclose protected health information (PHI) about you as a patient. Regulations mandate that we obtain written patient consent before releasing your private health information to family members, caregivers, and/or friends. This form summarizes the anticipated use of information about you for which this authorization is required. Valley Eye Specialists, P.L.C. and Valley Outpatient Surgical Center, Inc. provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

_____ I have been given a copy of the Notice of Privacy Practices.

I authorize Valley Eye Specialists, P.L.C. and/or Valley Outpatient Surgical Center, Inc. staff to use or disclose information regarding the specific purposes marked below. (please check all that apply).

_____ I authorize Valley Eye Specialists, P.L.C. and/or Valley Outpatient Surgical Center, Inc. staff to use or disclose information regarding the specific purposes marked below. (please check all that apply).

_____ Obtain information from designated individuals regarding my past and current health history, medications, previous surgeries, billing and/or insurance, and other relevant information.

_____ Obtain information from designated individuals regarding my post operative status, (i.e., postop calls).

_____ Provide information to designated individuals regarding my surgery/procedure, including preop instructions, arrival time, date of surgery, and any remaining balances due.

_____ Provide information to designated individuals regarding questions about my clinical and/or surgical diagnosis, treatment and care, drop instructions, billing and/or insurance, and surgery (if applicable).

I authorize the following designated individuals to provide and/or obtain information about myself regarding the purposes marked above.

List full name and relationship, phone number, if applicable. _____

_____

_____

Expiration date of this authorization (circle one): **None** or **Specific Date:** _____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing the form, I authorize Valley Eye Specialists, P.L.C. and/or Valley Outpatient Surgical, Inc. to use and disclose protected health information about me for the reasons mentioned above. I have the right to revoke this authorization at any time, in writing, signed by me. However, I understand such a revocation shall not affect any disclosures that have already been made in reliance on my prior authorization. I may submit a revocation to the Privacy Officer at 160 West University Drive, Suite 1, Mesa, Arizona 85201.

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Printed Name of Patient Signature of Patient/Legal Representative Date

Printed Name of Witness	Signature of Witness	Date