McDonald Eye Associates

3318 N. North Hills Blvd. • Fayetteville, AR 72703 • Phone: 479.521.2555 • Fax: 479.521.6761
5212 W Village Parkway #6 • Rogers, AR 72758 • Phone: 479.464.9702 • Fax: 479.464.9706

HIPAA AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name _____ Guardian or Authorized Party Name _____

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 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 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 relased ☐ From ☐ To _____

_____

_____

_____

☐ From ☐ To

McDonald Eye Associates

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Fayetteville, AR 72703	Rogers, AR 72758
Fax: 479.521.6761	Fax: 479.464.9706

_____ (Initials of patient or guardian) I understand that MEA 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, alcohol absuse, psychological/psychiatric conditions, or HIV information ☐ I DO ☐ I DO NOT authorize the release of this information.

**If an individual's personal representative signs this authorization, 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.

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