AUTHORIZATION TO RECEIVE/RELEASE PROTECTED HEALTH INFORMATION

Patient Name____D.O.B.__________________

Phone Number______________________ E-Mail ____

I authorize Valley Eye Associates/Park Place Optical to communicate with, and release my protected health information to the following individuals. This includes information about my appointments, care plan and billing. I understand that this authorization will remain in effect until I choose to revoke it.

____ _____________________________________

Name of Individual Relationship to Patient

____ _____________________________________

Name of Individual Relationship to Patient

____ _____________________________________

Name of Individual Relationship to Patient

____ _____________________________________

Name of Individual Relationship to Patient

___ I am opting out of Valley Eye Associates communicating with other individuals

____

Individual Signature Date

(If signed by anyone other than individual, state with signature relationship and authority to do so).

PLEASE SEE OTHER SIDE>>

Purpose: Valley Eye Associates may need to contact you for marketing communications that may benefit you and improve your quality of life.

I hereby give my consent to Valley Eye Associates/Park Place Optical to make the following communications:

Leave a message for me on my answering machine or cell phone………….____Yes ____No

Send me information in the mail, including newsletters and special event announcements about products and services of Valley Eye…………………………………………………..… ____Yes____No

Text message event reminders………………………………………………………………____Yes____No

Informational e-mails……………………………………………………………………………____Yes____No

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that if I sign this form I can receive a copy of it. I understand I am not obligated to sign this authorization, and that Valley Eye Associates/Park Place Optical may not condition treatment or payment on my decision to sign this authorization, except regarding research related treatment. I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Valley Eye Associates Privacy Officer. I understand my withdrawal will not be effective until received by the Privacy Officer and will not be effective regarding the uses and/or disclosures of my health information that Valley Eye Associates has made prior to receipt of my withdrawal statement. I understand if Valley Eye Associates uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. I understand that I have a right to a copy of the health information I have authorized to disclose for a reasonable fee. I may arrange to receive a copy of my health information by contacting the Valley Eye Associates Medical Records Department.

I understand that the information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

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Individual Signature Date

(If signed by anyone other than individual, state with signature relationship and authority to do so).