Clark | Tait
EYE CENTER
Keeping You In Focus

7329 Grand River Road
Brighton, Michigan 48114
810 474-3937 – fax 810 474-3940

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name _____ Birthday _____

MR# _____ SS#: _____

Information to be released from: _____
_____
_____
_____

Information to be released to: _____
_____
_____
_____

Specific information to be disclosed (include dates or treatment):

_____
_____

Purpose and need for such disclosure:

_____
_____

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 uses and disclosures already made based upon my regional permission cannot be taken back. **To revoke this authorization, I must do so in writing and send it to Clark Tait Eye Center, 7329 Grand River Road, Brighton, Michigan 48114.** This authorization will expire in six months from date of signature.

I understand that information used for disclosure with my permission may be re-disclosed by the recipient and no long protected by federal privacy standards.

I have read the above and acknowledge that I fully understand the terms and condition of this authorization.

Patient signature: _____ Date: _____

If the patient is unable to sign, or is a minor, complete the following:

_____ _____ _____
Parent/responsible relative/Legal guardian Relationship Date

Patient unable to sign because: _____

_____ _____
Witness Date