**HIPAA Authorization for Release of Patient Information**

Name of Patient:

Date of Birth:

**VIRGINIA EYE INSTITUTE** (VEI) is authorized to release Protected Health Information (PHI) about the above named patient for purposes of Treatment, Payment and Healthcare Operations, and to the entities named below by the Patient or their Legally Authorized Representative. VEI or its authorized agents, to include debt collection professionals, may contact me by telephone, to include mobile phones I am authorized to use, and may use electronic means of managing these phone calls to me.

**VEI may contact me via Text Message \_\_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_\_\_\_ NO**

**My HIPAA Protected Health Information (PHI) may be shared with the following entities** (please note any limitations to the persons’ right of access to your PHI i.e. “disclosure for appointment management only”):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Unless I have otherwise noted, the above named parties have full right of access to my PHI. I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. It is the patient’s responsibility to keep this information current.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Signature of Patient/ Legally Authorized Representative

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**FOR NEW PATIENTS ONLY: Acknowledgement of Receipt of Notice of Privacy Practices (NPP)**

I have received or have been offered a copy of the Notice of Privacy Practices for the above named practice. I understand that I may ask questions to VEI if I do not understand any information contained in the Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Signature of Patient/ Legally Authorized Representative

**For Office Use Only:**

We were unable to obtain a written acknowledgement of receipt of the NPP from the patient because:

\_\_\_\_ An emergency existed & a signature was not possible at this time.

\_\_\_\_ The individual refused to sign.

\_\_\_\_ Unable to communicate with the patient for the following reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_