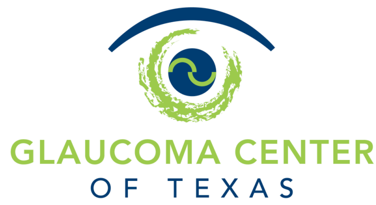


Patient Authorization To Release Protected Health Information

I authorize Glaucoma Center of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period that I am a patient at Glaucoma Center of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

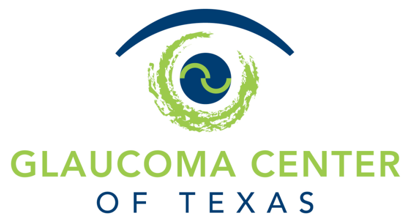
I further understand that I may revoke this authorization at any time by notifying *Glaucoma Center of Texas* in writing at *9600 N. Central Expressway, Suite 300, Dallas, Texas 75231.* I also understand that the written revocation must be signed and dated with a date that is later that the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

Relationship to Patient or Legal Authority



CONSENT

TO THE USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Glaucoma Center of Texas (hereinafter referred to as “Glaucoma Center”) will maintain a record of the care and services you receive at Glaucoma Center. This consent only covers your protected health information created while you are a patient of Glaucoma Center. Your protected health information pertains to your diagnosis and/or treatment at Glaucoma Center, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (“HIV”), and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Glaucoma Center’s use and/or disclosure of protected health information about you for treatment, payment, and health care operations and as otherwise allowed by law. Our *Notice of Privacy Practices* provides information about how Glaucoma Center and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of Glaucoma Center’s Notice of Privacy Practices and an opportunity to review it before signing this consent.

Patient’s Signature (*or Authorized Representative/Guardian*)	Patient Date of Birth
Witness’s Signature	Date