

MEDICAL EYE SERVICES, Inc.
HIPAA Authorization Form for Disclosure of Protected Health Information

This form, when signed at my request, will authorize Medical Eye Services, Inc. (MES) to disclose specified Protected Health Information (PHI)

1. I hereby authorize the disclosure of the following patient's PHI:

Patient Name: _____

Patient's Date of Birth: _____

Policyholder's Name: _____

Policyholder's Social Security or ID#: _____

2. The following person(s) is/are authorized to receive this PHI information:

The authorized recipient(s) named above may not re-disclose this PHI unless authorized by the patient. Patient shall hold harmless MES in the event the authorized recipient(s) makes a non-permitted use or disclosure of this patient's PHI.

3. Please check the following information to be disclosed:

<u>Documents</u>	<u>Date of Service (optional)</u>
_____ Complete routine vision care record(s)	_____
_____ Eye Examination records	_____
_____ Eyewear records	_____
_____ Eligibility Enrollment records	_____
_____ Correspondence	_____
_____ Other: _____	_____

4. The patient or legally authorized representative **MUST INITIAL BELOW** to acknowledge the following statements:

_____ I understand that I generally may revoke this authorization at any time by written notification to:
(Such revocation will not have any affect on actions taken by MES prior to the revocation.)

Medical Eye Services, Inc.
Attn: Benefit Resolutions Department
P.O. Box 25209
Santa Ana, Ca 92799-5209

_____ Unless otherwise revoked, this authorization will expire one (1) year from the date signed below
or on the following date: ____/____/____.

_____ I understand that MES will forward a copy of this signed authorization form to the patient at the
address on file once it is received by MES.

By signing below, I am attesting that I have the legal right to authorize the release of this patient's PHI.

Signature: _____ **Date:** _____

Printed name: _____

Relationship to patient (if signing as legally authorized representative)

Signing this authorization form will not affect treatment, payment, enrollment, or eligibility for benefits.