Horizon Eye Specialists & LASIK Center

Acknowledgment: Receipt of Notice of Privacy Practices Authorization of Use and Disclosure of Protected Health Information for Individuals

Persons Authorized to Receive Information:
Health information that Horizon Eye Specialists & LASIK Center collects or received about you may be disclosed to the following persons:

Name of person	Relation	Phone #
Name of person	Relation	Phone #

Use and Disclosure of Information:
I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Horizon Eye Specialists & LASIK Center.

Validity of Authorization
This authorization is effective unless revoked or terminated by the patient or patient's personal representative in writing.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Horizon Eye Specialists & LASIK Center. You should contact our Privacy Officer to terminate this authorization.

Potential to Re-disclosure
The person to whom health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

☐ I acknowledge receipt of NOTICE OF PRIVACY PRACTICES.

☐ I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information, to be released to the person(s) listed above.

Signature

Signature of Patient	Date
Name of Patient (Print or Type)	MRN
Signature of Patient Representative	Relationship to Patient