HIPAA Privacy Authorization Form
The Center for Vision Development
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Authorization for Use or Disclosure of Protected Health Information (PHI)
(Required by the Health Insurance Portability Act—45 CFR Parts 160 and 164)

Patient: ____

1. I, ____, hereby authorize The Center for Vision Development (TCFVD) to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named:____.

2. Authorization for the release of PHI (check one) to:____

   a) ☐ From (date) ______________________to (date) ____________________________ or,
   b) ☐ All past, present and future periods.
   c) ☐ My complete medical record with the exception of the following,
      ☐ Other (please specify):____
   d) ☐ None (exempt in circumstances defined in the Notice of Privacy)

3. In addition to the authorization for the release of my PHI described in section 2 of this Authorization (if applicable), I authorize disclosure of information regarding my billing, appointments, and treatment to the following individual(s):

   Name:____ Relationship:_____________________________

   Name:____ Relationship:_____________________________

   Name:____ Relationship:_____________________________

   ☐ None

4. This authorization shall be in force and in effect until nine (9) months after my death or____________________ (date or event) at which time this authorization will expire.

____ ________________________________
Patient Name Date

____
Patient Signature

____ ____
Parent/Patient Representative Name Parent/Patient Representative Signature

____ ________________________________
Office Representative Signature Date