Eye Surgery Associates of Zanesville, Inc.

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Medical, Surgical and
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www.zanesvilleeyes.com

Privacy Practice Notice and Authorization for Disclosure of Protected Health Information

Patient Name: ________________________ **Date of Birth:** ______________

I have received or have been offered a copy of Eye Surgery Associates and/or InSight Surgery and Laser Center Notice of Privacy Practices. I understand that my protected health information may be used by the Practice as described in the notice, for the purpose of my treatment, payment of services, or in the performance of health care operations of Eye Surgery Associates and/or InSight Surgery and Laser Center.

Eye Surgery Associates and/or InSight Surgery and Laser Center reserve the right to change the privacy practices that are described in the Notice. I may obtain a revised notice by calling the office and requesting a revised copy be sent to me. Otherwise, a revised copy will be given/offered to me at the time of my next appointment.

Purpose of authorization – It is the policy of this practice to provide communications with patients, as stated in our Notice of Privacy Practices, "by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care". The practice requires the following authorization for the release of protected health information via alternative means (other than the primary phone number that you have provided).

I authorize the practice to disclose or provide protected health information (as described below) directly to me at the email address, (via patient portal), home phone number, cell phone number or alternative address that I have indicated below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

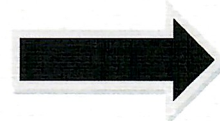
Purpose of disclosure – I am authorizing alternative means of communication for disclosure of my protected health information to ensure the confidentiality of communications from the practice.

Right to revoke or terminate -- As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to Eye Surgery Associates, Attn: Privacy Manager or to InSight Surgery and Laser Center, Attn: Privacy Manager.

Non-Conditioning statement -- The practice places no condition to sign this authorization on its' delivery of healthcare or treatment.

Re- disclosure statement – I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or other number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

PLEASE FILL OUT THE BACK



Expiration or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination date in writing to the practice. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

Method of contact -- I authorize the practice to contact me by cell phone, email address, home phone or by US Mail at the phone number(s) or address that I provided, unless I specify in writing to the practice that I do not wish to be contacted by certain methods.

I authorize the practice to leave a voicemail on the phone number(s) that I provided, unless I specify in writing to the practice that I do not wish to have voicemails left on the number(s).

Description of information to be disclosed – I authorize the practice to disclose my protected health information to me, via the method listed above, or to my designated personal representative, unless I specify in writing to the practice otherwise. The information disclosed may pertain to my appointment, my exam, my prescription, or my test results.

Personal representative --
I authorize the practice to discuss any of my personal health information with the following.

Name:______________________________ Relationship:____________________ Phone:____________________

Name:______________________________ Relationship:____________________ Phone:____________________

Name:______________________________ Relationship:____________________ Phone:____________________

____ ________________________

Patient Signature **Date**

Do you have a **Power of Attorney** for medical purposes? **Yes** □ **No** □

Power of Attorney Name:__________________________________ **Phone:**______________________

If possible, please provide a copy of Power of Attorney.

Patient Medical Record Number: ____________

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