GRIFFIN & REED
EYE CARE
A MEDICAL CORPORATION

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HIPAA Authorization for use or disclosure of Health Care Information

Patient Name _____ Date of Birth _____ Social Security Number _____

Maiden or Other Names _____ Guardian or Authorized Party _____

I authorize the use and disclosure of my healthcare information as described below:

☐ **Records relating to treatment dates from _____ to _____.**

☐ **Records for all care at this facility or by this doctor.**

☐ **Other (please be specific) _____**

I understand that I have the right to revoke this authorization in writing at any time except: (1) where the uses of disclosures have already been made based upon my original permission, (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

To evoke the authorization, I must do so in writing and without my revocation. This consent will automatically expire within 90 days from today's date. State and federal laws specify record requests must be acted upon within 30 days if information is maintained or accessible on site otherwise within 60 days.

Information to be released **___From ___To** _____

_____

_____

___From ___To **Griffin & Reed Eye Care**

651 Fulton Ave
Sacramento, CA 95825
Ph. 916-483-2525
Fax 916-483-2636

5 Medical Plaza Dr, Ste. 280
Roseville, CA 95661
Ph. 916-784-2020
Fax 916-784-2082

_____ _____
Signature of Patient or Guardian Date

A fax copy or photocopy of this consent shall be as valid as the original.

FEES: The fee is $15.00. State and federal laws specify a reasonable charge to offset the cost associated with the reproductions of records. There is no fee for reproducing & forwarding records to referring physicians currently involved with patients continuing care.