The Eye Institute of Austin
Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____

Date of Birth _____ Medical Record # _____

Home Phone #_____ Cell Phone #_____

Address _____

City _____ State _____ Zip Code _____

I hereby authorize _____ **FAX #** _____
to use or disclose my protected health information as indicated below to:

Name: **Eye Institute of Austin** Phone#: **512-454-8744** Fax#: **512-451-3447**
Address: **3300 W. Anderson Lane #308**
City**: Austin** State: **TX** Zip Code**: 78757**

Information to be released:

From and to dates_____

- ☐ History and Physical Exam_____
- ☐ Lab Report_____
- ☐ X-ray Report_____
- ☐ Consultation Report_____
- ☐ Other_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

The confidentiality of this record is required under Texas Administrative code Title 25 Part 1 Chapter 414 subchapter A and Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X_____ _____
Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

- ☐ Changing Physician
- ☐ Continuing Care
- ☐ At My (patient) request
- ☐ Second opinion
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Other_____

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying The Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as genetic test results, substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient or Legal Guardian/Authorized Person Date

THE EYE INSTITUTE OF AUSTIN
3300 W. Anderson Lane, Suite 308 ● Austin, TX 78757
Phone: 512-454-8744 ● Fax: 512-454-0107