ASHEVILLE VISION ASSOCIATES

Authorization for Use & Disclosure of Protected Health Information *HIPAA

*HIPAA - Health Insurance Portability and Accountability Act, a 1996 Federal law that restricts access to individuals' private medical information.

Patient Information

Name: _____

Date of Birth: _____/_____/_____

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) listed above and may no longer be protected by AVA.

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Signature _____ **Date** ____/____/_____