EYECARE ASSOCIATES
OF SAN FRANCISCO

UNION SQUARE
360 Post Street, Suite 1005
San Francisco, CA 94108
Office: (415) 982-2020
Fax: (415) 982-2011

STONESTOWN
595 Buckingham Way, Suite 448
San Francisco, CA 94132
Office: (415) 564-1060
Fax: (415) 564-3368

MEDICAL & SURGICAL DISEASES OF THE EYE
COMPREHENSIVE OPHTHALMOLOGY
WWW.EYECARESF.COM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize ECASF to use and disclose health information concerning

_____

(Patient Name And Address)

Health information to be used or disclosed (check only one box):

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

☐ All psychotherapy notes may be released, except as specifically provided below:

_____

This health information may be disclosed to:

_____

(Name and address of person to use or receive the health information)

The information may be used only for the following purposes. If you do not want to explain the purpose, write "*At the request of the individual*":

_____

_____

_____

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I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

This authorization is effective now and will remain in effect until:

_____

(Expiration event or date)

I understand that I have the right to receive a copy of this authorization.

Signed:_____ Print Name: _____ Date: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

PLEASE ALLOW FIVE BUSINESS DAYS TO PROCESS MEDICAL RECORD REQUESTS

Please send all requests to:

Jairi Vargas, Privacy & Security Officer
Office Phone: (415) 982-2020
Office Fax: (415) 982-2011