



**FRONT RANGE
EYE PHYSICIANS**
205 S. Main St., Suite D - Longmont CO 80501
Phone: (303) 772-3611

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act (HIPAA) 1996

*I understand that Front Range Eye Physicians PC may not use or disclose my health information, except as noted in our Privacy Statement, without my written authorization.

*I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent my receipt of health care or eligibility for benefits under a health plan.

*I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

*I understand that information disclosed here may be re-disclosed to additional parties and no longer protected.

*I understand that I may revoke this authorization in writing at any time, except where releases have already been made based upon my original permission.

*I understand that I am entitled to receive a copy of this form upon signing it. *This authorization expires 1 year after date of signature or when revoked in writing as above.*

***I hereby authorize the use and disclosure of my individually identifiable health information as described below.**

Patient Name _____
Date of Birth

I authorize all of my health information OR some of my health information as described below:

*the period of healthcare from (date) _____ to (date) _____

Person or organization authorized to release my health information: Front Range Eye Physicians, PC

Person or organization authorized to receive my health information:

Name _____
Phone Number _____
Relationship

Name _____
Phone Number _____
Relationship

Name _____
Phone Number _____
Relationship

Signature _____
Date

(If signed by a patient representative):

Representative Name (print) Relationship to Patient & Authority Status