SCOTTSDALE
EYE PHYSICIANS & SURGEONS, PC

HIPAA Privacy Authorization Notice

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my personal health information.

A copy of the Notice of Privacy Practices has been made available for my review. I understand the office will use and disclose my protected health information to provide my medical care, receive payment for services provided to me, and to conduct its business.

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Printed Patient Name _____

Patient/Legal Guardian Signature _____ Date _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Patient receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Reason: _____

Initials: _____

Rev 09/2014

7550 E Second Street | Scottsdale, AZ 85251 Monday – Friday 8AM to 5PM

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