AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

HOPE EYE CENTER, PLLC

IDENTIFICATION:

Last Name: _____ First Name: _____ Middle:_____

OTHER NAME(S) USED: _____

DATE OF BIRTH. Month: _____ Day: _____ Year: _____

PHONE: _____ **EMAIL:** _____

(1) I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Name: Robert Cizik Eye Clinic/UT Ophthalmology
Address: 6400 Fannin St, Suite 1800 .
City: Houston .
State: TX . Zip Code: 77030 .
Phone: 713-486-9400 .
Fax: 713-486-9592 .

(2) WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Name: HOPE EYE CENTER, PLLC .
Address: 4645 Southwest Fwy, .
Suite 100 .
City: Houston .
State: TX . Zip Code: 77027 .
Phone: 713-467-3393 .
Fax: 832-467-3393 .
Email: info@hopeeyecenter.com .

(3) ***REASON FOR DISCLOSURE***

___ Treatment/Continuing Medical Care
___ Other: _____

(4) ***WHAT INFORMATION CAN BE DISCLOSED?***

___ All health information
___ Other: _____

Your initials are required to release the following information:

_____ Genetic Information _____ HIV/AIDS Test Results/Treatment

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE: X_____

Signature of Individual or Individual's Legally Authorized Representative

DATE: _____

Printed Name of Legally Authorized Representative (if applicable):

_____

If representative, specify relationship to individual:

___ Parent of minor ___ Guardian ___ Other: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, or substance abuse, and mental health treatment (See, *e.g.*, Tex. Fam. Code § 32.003).

SIGNATURE: X_____

Signature of Minor Individual

DATE: _____