Central Washington Eye Clinic

Authorization to Receive/Release Health Information

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below:

Patient Name: _____

Do you have a particular person or family member(s) that you authorize to receive and discuss information regarding your personal health information (general, surgical and billing information)?

□ **No** □ **Yes**, if yes please provide:

Name: _____ **Relationship**: _____

Phone Number: _____

□ **No** □ **Yes**, if yes please provide:

Name: _____ **Relationship**: _____

Phone Number: _____

Is this person your **Power of Attorney** (POA) for medical purposes? □ **No** □ **Yes**

Note: If you do have a Power of Attorney for medical purposes, please provide Central Washington Eye Clinic a copy of your documentation.

We keep a record of the health services we provide you. You may request to view and copy your health record; we may charge you a fee to copy those records. You may also request to have your record amended. We will not disclose your records to others unless your direct us to do so or unless the law authorizes or compels us to do so. You may submit your request to view your record or request further information regarding our HIPAA policy by contacting our Privacy Officer at (509) 452-6611.

Our Notice of Privacy Practices describes in detail how your health information may be used, disclosed and how you can access your information. You may request a complete copy of our Notice of Privacy Practices from our reception desk.

By signing below, I acknowledge receipt of the Notice of Privacy Practices summary.

_____ _____

Patient or Legally Authorized Individual **Date**