NUCCIO OPTOMETRISTS

Michael J. Blinstrup, O.D. & Richard J. Nuccio, O.D.

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Nuccio Optometrists is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Nuccio Optometrists, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

[ ] The patient's entire health record
(NOTE: This requires an explanation why the entire record may be disclosed)

[ ] The patient's demographic information (check all that apply):
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other:_____

[ ] Health Data/Information as related to:
[ ] Specific condition: _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Name(s) or class of person(s) other than the current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:

_____

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's rotected health information:

_____
_____
_____

Purpose(s) of the information:

_____
_____

136 W. Lake Street, Suite 110
Bloomingdale, Illinois 60108

T: 630.980.9095
F: 630.980.9156

nuccioOpt@sbcglobal.net
nuccioOpt.com

Please check if applicable:

[ ] This authorization is to be used for our own use, and Nuccio Optometrists will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

[ ] The patient understands that Nuccio Optometrists may receive financial gain as a result of disclosing this information due to _____

[ ] This authorization permits Nuccio Optometrists to send the protected health information ONLY to this address or fax number:

_____

_____

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or, if applicable, during a contestibility period. In order for the revocation of this authorization to be effective, Nuccio Optometrists must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable
- The effective date of this authorization, and the recipients of the protected health information according to this authorization.
- The patient's desire to recoke this authorization, and
- The date of the revocation, and the patient's signature.

Nuccio Optometrists will accept written revocations of this authorization via:
[ ] Certified U.S. Mail
[ ] Facsimile at this number: 630.980.9156

ALL revocations must be sent to Nuccio Optometrists to the attention of the Privacy Officer, (PO NAME), and are not effective until received by the privacy officer.

This authorization shall expire on _____. At this date, Nuccio Optometrists can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.
Authorization verified by _____ on _____.

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