GENERAL AUTHORIZATION FOR PROTECTED HEALTH

USE AND DISCLOSURE OF INFORMATION

By signing this form, I hereby authorize Associated Vitreoretinal and Uveitis Consultants to obtain, use and disclose certain protected health information from the records of:

Name: _____ DOB: _____
Address: _____
Daytime Phone #:_____ Email address:_____

The following information may be used and disclosed (specifically identify the records, if entire medical record is requested state that): _____
_____
_____
_____

Persons/organizations providing the information (please include address or location):
_____
_____
_____
_____

The purpose for which the records will be used and disclosed is as follows (check one):
( ) At the request of the patient
( ) Other (specifically identify the purpose): _____

I understand that I may revoke this authorization in writing at any time, except that such revocation will not affect actions already taken in reliance on this authorization and, if applicable, may not be effective as to an insurer's right to contest a claim. I understand that, in order to revoke this authorization, I must send a written notice stating my intent to revoke this authorization to:

PRIVACY OFFICER
Associated Vitreoretinal and Uveitis Consultants
12794 Hamilton Crossing Blvd.
Carmel, Indiana 46032

Unless revoked earlier, this authorization will expire (choose only 1):
( ) On the following date:
_____

Ramana S. Moorthy, MD, Rodney S. Bucher, MD, F. Ryan Prall, MD,
Mark M. Kaehr, MD, Rita K. Singh, MD, Julia Hudson, MD

12794 Hamilton crossing blvd, carmel in 46032 | 5250 E US Highway 36 Suite 620, Avon in 46123
2929 S. McIntire Drive Bloomington IN 47403 | 1900 Chester Blvd Richmond IN 47374
800 S. Tillotson Ste 3 Muncie In 47304
Phone**317-571-1501 Fax**317-571-4806

( ) Upon the following 

event:

_____

If no expiration date or event is given, it is assumed that the authorization will expire one year after it is signed.

I understand that the Practice is not conditioning treatment and/or payment upon my agreement to sign this Authorization.

I understand that the information to be used and disclosed pursuant to this authorization form may include sensitive information such as information relating to (1) human immunodeficiency virus ("HIV") infection or acquired immunodeficiency syndrome ("AIDS"), (2) treatment for or history of drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

I understand that to the extent any recipient of this information, as identified in Paragraph 3 above, is not a "covered entity" under federal privacy law, the information may no longer be protected by federal privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

Signature: _____ Date: _____

If the authorization is signed by a Legal Representative of the Patient:

Printed name of Legal Representative:
_____

Representative's authority to act for the Patient:
_____

If signed by the Legal Representative of the Patient, we must verify that you are this Patient's representative under state law for purposes of filing this Authorization before we can act on it. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc.). As this patient's representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide your mailing address, e-mail address and phone number:

_____
_____
_____
_____

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