Rock Hill Eye Center

Authorization of Privacy Practices

Patient name: _____ DOB: _____

Address: _____

I. My Authorization

You, Rock Hill Eye Center, may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by you

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization ends (check all that apply):

☐ on (date): _____

☐ when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment.

I may revoke this authorization at any time, in writing, sent to Rock Hill Eye Center at the address provided below. If I do, it will not affect any actions already taken by Rock Hill Eye Center based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

· 1773 Ebenezer Road, Rock Hill, SC 29732

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I have received a copy of the Notice of Privacy Practices for the Rock Hill Eye Center.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Print Name Relationship