Dr. Aimee Pecori OD
Christine McBride *Office Manager*
Misti Tousley *Optical Manager*

BEACON
FAMILY EYE CARE

173 East Main Street
Gouverneur, NY 13642
P: 315-535-1700 F: 315-535-1704

Authorization for Use and Disclosure of Health Information

Patient Name _____ Date of Birth _____
Address _____ Phone Number_____

By signing this form, I hereby authorize _____to disclose the health information described below to *(Name, address, phone, and fax of Person or Organization)* :

_____

Check all that apply:

___ All health information ___ Health information relating to the following treatment or condition
___ Health information for the date(s) ___ Other specific description

Reason for This Authorization:

___ At my request ___ Other (specify)_____
___ requested this authorization for marketing purposes and will/will not receive compensation from a 3rd party

This authorization expires upon *(date or description of event)* _____

- I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.
- I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.
- Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ _____
Patient/Legally Authorized Representative **Date**

_____ _____
Printed Name **Relationship to Patient**

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.