Lakeside Ophthalmology Center, Robert G. Mobley, M.D., P.C.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Printed Name:_____
Date of Birth:_____
Social Security Number:_____

I authorize Lakeside Ophthalmology Center to use or disclose my protected health information to the following persons or entity: **please provide a name, address, and fax number if necessary for submission of records**

_____
_____
_____

I understand that the protected health information, which is used or disclosed pursuant to this Authorization, may be subject to re-disclosure by the recipient and may lose the protection of confidentiality under the privacy rules.

I understand that I have the right to inspect and copy the protected health information that will be used or disclosed pursuant to this Authorization

I understand that Lakeside Ophthalmology Center will not condition any aspect of my treatment, payment, enrollment in the health plan or eligibility for benefits on whether or not I sign this Authorization

I understand that I am under no obligation to sign this Authorization

I understand that this Authorization will automatically expire on: _____.

I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to _____, unless:

a) Lakeside Ophthalmology Center has previously acted in reliance on this Authorization;

b) Or if this Authorization was executed as a pre-condition to obtaining insurance coverage, other laws provide that the insurance company has the right to review/defend pursuant to the terms of the insurance policy.

By my signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my Authorization to Lakeside Ophthalmology Center to use or disclose my protected health information in accordance with the terms of this Authorization.

Signature of Patient or Guardian or Authorized Rep Date

Printed name of Guardian or Authorized Rep

Signature of Witness Date

Revocation Section

I hereby revoke this Authorization

Signature Date