# MEDICAL EYE SERVICES, INC.
## HIPAA Authorization Form for Disclosure of Protected Health Information

This form, when signed at my request, will authorize Medical Eye Services, Inc. (MES) to disclose specified Protected Health Information (PHI)

1. I hereby authorize the disclosure of the following patient's PHI:

Patient Name: ______________________________

Patient's Date of Birth: ______________________________

Policyholder's Name: ______________________________

Policyholder's Social Security or ID#: ______________________________

2. The following person(s) is/are authorized to receive this PHI information:

______________________________

*The authorized recipient(s) named above may not re-disclose this PHI unless authorized by the patient. Re-disclosure by the authorized recipient is no longer protected by MES. Patient shall hold harmless MES in the event the authorized recipient(s) makes a non-permitted use or disclosure of this patient's PHI.*

3. Please check the following information to be disclosed:

| Documents | Date of Service (optional) |
|---|---|
| ☐ Complete routine vision care record(s) | ____________ |
| ☐ Eye Examination records | ____________ |
| ☐ Eyewear records | ____________ |
| ☐ Eligibility Enrollment records | ____________ |
| ☐ Correspondence | ____________ |
| ☐ Other: ____________ | ____________ |

4. The patient or legally authorized representative **MUST INITIAL BELOW** to acknowledge the following statements:

__________ I understand that I generally may revoke this authorization at any time by written notification to: (Such revocation will not have any affect on actions taken by MES prior to the revocation.)

Medical Eye Services, Inc.
Attn: Benefit Resolutions Department
P.O. Box 25209
Santa Ana, Ca 92799-5209

__________ Unless otherwise revoked, this authorization will expire one (1) year from the date signed below or on the following date: __________.

__________ I understand that MES will forward a copy of this signed authorization form to the patient at the address on file once it is received by MES.

By signing below, I am attesting that I have the legal right to authorize the release of this patient's PHI.

***Signature:*** ______________________________ ***Date:*** ______________________________
*(Patient or Authorized Patient Representative)*

***Printed name:*** ______________________________

______________________________

***Relationship to patient (if signing as legally authorized representative)***

***Signing this authorization form will not affect treatment, payment, enrollment, or eligibility for benefits.***