AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Cabot Family Eye Care, Inc.
32 South Pine Street, Suite 1
Cabot, AR 72023
501-843-6567
Robyn Stamper, Privacy Official

Patient Name_____Date_____

I authorize Beebe Family Eye Care, Inc. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

My protected health information will be disclosed, minimally as necessary, to facilitate my treatment, insurance payment, and other business operations. Any disclosure of my protected health information (for uses other than treatment, payment, or health care operations) must have my prior authorization.

This agreement will remain in place until such time as you, the patient, tell us, either in person or in writing, that you wish to change with whom we may disclose your protected health information.

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX, or email the Privacy Official noted in the *Notice of Privacy Practices.*

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

You have my permission to discuss any aspect of my protected health information with:

Spouse _____ Other _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Beebe Family Eye Care, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Beebe Family Eye Care, Inc.'s Notice of Privacy Practice and agree to continue my care with Beebe Family Eye Care, Inc. under said terms.

- I was given the opportunity to read Beebe Family Eye Care, Inc.'s Notice of Privacy Practices and declined but wish to continue my care with Beebe Family Eye Care, Inc. under the terms of Beebe Family Eye Care, Inc.'s privacy policies.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient or Representative (relationship) Date