BROWN®
RETINA INSTITUTE

AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION (PHI

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On Occasion, the patient and the Practice may want to use PHI for reasons other that treatment , payment and health care operations. This form summarizes the anticipated use of information about you for which the authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I,_____ (Patient), give Brown Retina Institute permission to disclose the details of my medical record to the following individuals:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Please check off the following details which may be disclosed to the individuals listed above:

____ Any and all items related to Brown Retina Institute ____ Exam dated_____

____ Medications _____ Billing

____ Or the following information:_____

_____

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons stated above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

_____ _____
Signature of Patient Date

_____
Printed Name of Patient

_____
Witnessed by Brown Retina Institute Employee