Janet A. Betchkal, M.D. P.A.

Practice Limited to Glaucoma & Related Eye Diseases -
wwwJanetBetchkalMD.com

AUTHORIZATION AND USE OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

This is an authorization under the Privacy of the Health Insurance Portability and Accountability Act of 1996 [45 CFR 164.508]. I authorize, Janet A. Betchkal M.D. P.A., my physician and/or administrative and clinical staff to (check all that apply):

☐ Use the following protected health information, and/or

☐ Disclose the following protected health information to
[*Name of entity or class of persons to receive information]:*

_____

_____

The name or class of people authorized to use or disclose are as follows:

_____

_____

The information to be used or disclosed is as follows: [*Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.]*

This protected health information is being used or disclosed for the following purposes: *[List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want tostate a specific purpose.]*

_____

_____

_____

This authorization shall be in force and effect until:

(1) _____
[Expiration date]

or (2) _____
[Event that relates to the patient or the purpose of the use or disclosure] at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 3 Shircliff Way, Ste 134, Jacksonville, FL 32204. I understand that a revocation is not effective to the extent that Janet A. Betchkal M.D. P.A. has relied on the use ordisclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization maybe disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health planor eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except:

(1) if my treatment is related to research, or
(2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. [*Patient initials, if applicable]* _____

_____
Signature of the Patient or Personal Representative

_____
Date

_____
Print name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

[Provide a copy of this form to the patient.]

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