

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)



COLORADO LASER SURGEONS

Lawrence D. Spivack, M.D.
Terrence S. Spencer, M.D.
Vandi W. Rimer, O.D.
Ketty Lee, O.D.

Patient Name

Address

Date of Birth

Social Security Number

Records relating to treatment dates from: _____ to _____

Records for all care at this facility

Information to be released [] From [] To

[] From [] To

Spivack Vision Center / Colorado Laser Surgeons
6881 S. Yosemite St.
Centennial, CO 80112
(303) 740-9310
Fax: (303) 740-5494

I understand that I have the right to revoke this authorization, in writing, at any time, except: (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation. This consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

Signature of Patient or Guardian**

** if this authorization is signed by an individual's personal representative, the representative's authority is based on:

(e.g., state law, court order, etc.)