HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Eyesite of Anthem, will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you agree that Eyesite of Anthem may disclose your personal health care information to_____[Identify intended recipients].

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Eyesite of Anthem's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Eyesite of Anthem has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Eyesite of anthem at any of its offices or by sending a written request with return address to 11540 So. Eastern Ave, Suite 100; Henderson, NV 89052.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Eyesite of Anthem for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Eyesite of Anthem has taken action in reliance on it. A revocation is effective upon receipt by Eyesite of Anthem of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Eyesite of Anthem, or (d) six years from the date this authorization was executed.

Please continue to the back side

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Eyesite of Anthem will provide _____ [name of patient] with a copy of this signed authorization.

Acknowledged and agreed to by:

PATIENT: _____

By: _____ _____
Date

Print Name: _____

Address: _____
_____
_____
_____

Or, ON BEHALF OF PATIENT

By: _____ _____
Date

Print Name: _____
As: _____

Address: _____
_____
_____
_____