NORTHWEST OHIO LIONS EYE CARE FOUNDATION, INC.
BECAUSE WE CARE

HIPAA Privacy Authorization Form
(Required by the Health Insurance Portability and Accountability Act,45 C.F.R.Parts 160 and 164)

1. Authorization for RELEASE OF MEDICAL INFORMATION:

I authorize_____**(healthcare provider/Doctor)** to use and disclose the protected health information described below to Northwest Ohio Lions Eye Care Foundation, Inc. ("Foundation").

2. Effective Period:
This authorization for release of information covers the period of healthcare for review and processing of my request to the Foundation for assistance.

3. Extent of Authorization:
I authorize the release of my **pertinent ocular/visual** information regarding my eyesight, together with any other information deemed necessary by the Foundation to determine whether to provide financial assistance to me. This information will be kept confidential by the Foundation.

4. This medical information will be used by the Foundation for requested evaluation, medical treatment or consultation with recommended medical providers.

5. This authorization shall be in force and effect until completion of my request's review and any treatment assistance from the Foundation, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits from a health care provider or health plan will not be conditioned on whether I sign this authorization.

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

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative & his/her relationship to patient.

Date: _____/_____/_____   *Please make a copy of this completed form for your records.*