ALAMO EYE INSTITUTE, P.A.
LYNNELL C. LOWRY, M.D.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____, hereby authorize Alamo Eye Institute, P.A., its agents and employees, to (check those that apply):

- ❑ use the following protected health information, and/or
- ❑ disclose the following protected health information to _____

Information to be disclosed:

Any information in chart

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

"Protected health information" means health information, including demographic information, collected from you and created or received by us, another health care provider, a health plan, your employer or a health care clearinghouse. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

This protected health information is being used or disclosed for the following purposes:

Medical Care

[List specific purposes here.]

This authorization shall be in force and effect until indefinite (unless term date entered) **[specify (1) 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 offices of Alamo Eye Institute, P.A. at 18720 Stone Oak Parkway, Suite 119, San Antonio, Texas 78258. I understand that a revocation is not effective to the extent that any of the above entities has relied on the use or disclosure of the protected health information.

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

Alamo Eye Institute, P.A., will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- ❑ Inspect or copy (there may be a charge for copying Medical Records) the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ❑ Refuse to sign this authorization.

_____ _____ _____
Signature of Patient or Personal Representative | Date | SS#

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority [documents confirming authority must be attached]