Dr. Crystal M. Brimer, OD

NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE AND TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION. A COPY OF OUR PRIVACY POLICY IS AVAILABLE IN THE OFFICE FOR ALL PATIENTS TO READ AND A PAPER COPY OF THIS POLICY IS AVAILABLE UPON REQUEST TO ANY PATIENT.

IN ORDER FOR US TO DISCUSS ANY OF YOUR PRIVATE INFORMATION WITH A FAMILY MEMBER OR FRIEND (INCLUDING YOUR SPOUSE), THEIR NAME(S) MUST BE LISTED ON THIS FORM IN THE SECTION BELOW.

1) I AUTHORIZE the office of Dr. Crystal M. Brimer, OD TO RELEASE MY HEALTH INFORMATION TO:

______________________________	______________________________
PERSON OR ENTITY	**RELATIONSHIP**
______________________________	______________________________
PERSON OR ENTITY	**RELATIONSHIP**

2) THIS AUTHORIZATION FOR RELEASE OF INFORMATION COVERS THE PERIOD OF HEALTHCARE:

☐ **FROM ________________ TO __________________ OR ☐ ALL PAST, PRESENT, AND FUTURE PERIODS.**

3) I AUTHORIZE THE RELEASE OF:

☐ **MY COMPLETE HEALTH RECORD**

☐ **MY COMPLETE HEALTH RECORD WITH THE EXCEPTION OF THE FOLLOWING INFORMATION:**

____

THIS MEDICAL INFORMATION MAY BE USED BY THE PERSON I AUTHORIZE TO RECEIVE THIS INFORMATION FOR MEDICAL TREATMENT OR CONSULTATION, BILLING OR CLAIMS PAYMENT, OR OTHER PURPOSES AS I MAY DIRECT.

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL ________________ (DATE OR EVENT), AT WHICH TIME THIS AUTHORIZATION EXPIRES.

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 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 MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON WHETHER I SIGN THIS AUTHORIZATION.

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.

____________________________________ **DATE** ____ / ____ / ______

PATIENT SIGNATURE

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PATIENT NAME (PLEASE PRINT)