Retina Consultants of Michigan
HIPPA AUTHORIZATION
For the use or disclosure of Health Information

By signing this form, I, _____, authorize the use and disclosure of my health information as described below:

1. **Description of information:**
   - Your name, address, and phone number.
   - Information relating to your medical history.
   - Your insurance information and coverage.
   - Information concerning your doctor, nurse or other medical providers.
2. **Name or class of person(s) or class or persons authorized to make the use or disclosure:**
   Employees of Retina Consultants of Michigan in the course of providing treatment, reporting results to referring physician offices and billing services to insurance carriers.
3. **Name or identification of person(s) or class of persons authorized to receive information:**
   Insurance companies, referring physician offices, other treating physicians, relatives or friends specifically authorized by the patient.
4. **Date or event when authorization expires:** This authorization **DOES NOT EXPIRE**.
5. **Description of each purpose of the requested use or disclosure:**
   Only for the purpose of treating the above identified patient, relaying information to the patient's referring physician and billing the claim for medical services to the correct insurance company.
6. **Research**
   RCM conducts clinical research in accordance with Federal Regulations and Good Clinical Practice guidelines. Your medical records may be reviewed by a doctor at RCM for inclusion in a research study. If data from your chart will be used in a retrospective study, the data will be de-identified. If you are determined to be potentially eligible for a prospective study, you may be contacted to discuss your interest in participating.
7. **Health information disclosure allowed to the following additional people:**

_____ _____

Name (relationship) Name (relationship)

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 send it to **Retina Consultants of Michigan**. 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.

_____**[Initials of patient or guardian]** I understand that Retina Consultants of Michigan may not condition treatment on my signing this authorization and that I have a right to refuse to sign the authorization.

_____ _____

Signature of Patient or Guardian** Date

_____

Print Name of Patient

_____

Print Name of Guardian

Revised 4/18/18