SAULT VISION CLINIC P.C.

HIPAA CONSENT DESCRIPTION

A HIPAA authorization is a detailed document in which specific uses and disclosures of protected health are explained in full.

By signing the authorization, an individual is giving consent to have their health information used or disclosed for the reasons stated on the authorization. Any use or disclosure by the covered entity or business associate must be consistent with what is stated on the form.

The authorization form must be written in plain language to ensure it can be easily understood and as a minimum, must contain the following elements:

Specific and meaningful information, including a description, of the information that will be used or disclosed

The name (or other specific identification) of the person or class of persons authorized to make the requested use or disclosure

The name(s) or other specific identification of the person or class of persons to whom information will be disclosed

A description of the purpose of the requested use or disclosure. In cases where a statement of the purpose is not provided, “at the request of the individual” is sufficient

A specific time frame for the authorization including an expiration date. In the case of uses and disclosures related to research, “at the end of the study” can be used or ‘none’ in the case of the creation of a research database or research repository

A date and signature from the individual giving the authorization. If the authorization is being given by an individual’s authorized representative, a description of the person’s authority to act on behalf of the individual must be detailed.

Statements must also be included on the HIPAA authorization to notify the individual of:

The right to revoke the authorization in writing and either:

- Exceptions to the right to revoke and a description of how the right to revoke can be exercised; or
- The extent to which the information is included in the organization’s notice of privacy practices
- The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization by stating either:

  That the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; or

  The consequences of a refusal to sign the authorization when the covered entity is permitted to condition treatment, enrollment in the health plan, or eligibility for benefits on a failure to obtain authorization.

  The individual providing consent must be provided with a copy of the authorization form for their own records.

HIPAA DISCLOSURE ACKNOWLEDGEMENT

- I understand that I may inspect or copy the protected health information described by this authorization.

- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Date:_____

Signature of Individual or Representative:_____

Authority or Relationship to Individual, if Representative:_____

EXPIRATION DATE:

(This authorization will expire on 7 years from signature date. If no date or event is stated, the expiration date will be seven years from the date of this authorization.)

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.