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SOUTH SHORE EYE CARE, LLP

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize South Shore Eye Care, LLP to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits South Shore Eye Care, LLP to use or disclose to _____

_____ the following individually identifiable health information (specifically
Person or Entity to Receive the information

describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). _____

This authorization will expire on _____.
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that South Shore Eye Care, LLP has acted in reliance upon this authorization. My written revocation must be submitted to South Shore Eye Care's Privacy Officer at 2185 Wantagh Avenue, Wantagh, N.Y. 11793.

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian