CLEAR FORM

Authorization for Disclosure Form

This form authorizes Community Eye Care (CEC) to use or disclose your information to a third party over the telephone on your behalf as you designate below. CEC will not disclose information collected on this form to any source other than what has been authorized under the HIPAA Privacy Rule (45 CFR Parts 160 and 164), which includes purposes of treatment, payment, and healthcare operations or as required by law.

Section I – Member Requesting Authorization to Use or Disclose Protected Health Information

First Name:	Middle Name/Initial:	Last Name:
Mailing Address/PO Box:		
City:	State:	Zip Code:
Member ID#:	Date of Birth (MM/DD/YYYY):	
Email:	Mobile Phone:	Daytime Phone:

Section II – Authorized Individual/Organization to Use or Received Protected Health Information

If authorization is for an organization, please provide the first and last name of the organization's representative.

Organization (if applicable):	First and Last Name:	
Mailing Address/PO Box:		
City:	State:	Zip Code:
Email:	Phone:	

Section III – Health Information to be Used and/or Disclosed

Specify the health information to be released and/or used:

- ☐ All my past, present, or future health claims, claims adjudication, eligibility information, and provider information.
- ☐ All my health information relating to date of service: _____
- ☐ My health information limited to prescription lens/eye care.

Note: *This authorization excludes disclosure of any information related to substance abuse, mental health, HIV diagnosis/treatment, and genetic information.*

- I understand I may revoke this authorization, except for actions already taken on my behalf, based on this authorization, at any time by sending a request in writing to CEC at the address listed below.
- I understand payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I am aware of my right to receive a copy of this authorization upon request.
- I understand information disclosed pursuant to this authorization could be redisclosed by the recipient. Such re-disclosure may not be prohibited by law and may no longer be protected by federal privacy regulations (HIPAA).
- I understand the completion of this form does not allow a third party to manage my care.

If a member's representative signs the authorization, attach documentation of the representative's authority (for example, power of attorney).

Section IV – Terms of Release of Protected Health Information

From the date of signing below until: _____
Please specify MM/DD/YYYY (not to exceed 24 months)

If no expiration date is specified, this authorization will expire 24 months from date of signature.

Section V – Signature

_____ _____
Signature of Person Giving Authorization Date (MM/DD/YYYY)

_____
Print Name of Person Giving Authorization

Please make a copy of your signed authorization before sending it to CEC. return this completed form and any related documentation to: **Community Eye Care (CEC), Attn: Privacy Requests, 4944 Parkway Plaza Blvd, Suite 200, Charlotte, NC 28217** or email to **info@cecvision.com**.

CEC USE ONLY		
Status	**Signature**	**Date of Review**
☐ Approved		
☐ Denied/Reason for Denial: ☐ Missing Signature/Incomplete ☐ No Supporting Documents ☐ Requestor is Not a Member ☐ Other _____		

Prohibition on redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and applicable federal/state laws.

This document may contain information covered under HIPAA and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify CEC immediately, then destroy the document and any copies you have made.