MARCH Vision Care INCORPORATED

AUTHORIZATION FOR THE USE OR DISCLOSURE OF AN INDIVIDUAL'S HEALTH INFORMATION

Individual's Information:

FIRST NAME, MIDDLE INITIAL, AND LAST NAME			DATE OF BIRTH (MM/DD/YYYY)
STREET ADDRESS		CITY	STATE
MEMBER ID#	GROUP ID#	TELEPHONE#	ZIPCODE

Part 1: I authorize the following person or types of people to disclose my protected health information:

MARCH Vision Care, Inc. and its affiliates and agents

Part 2: I authorize the following person or types of people to receive my protected health information:

NAME OF PERSON AUTHORIZED TO RECEIVE THE DISCLOSE INFORMATION (PERSON MUST BE AT LEAST 18 YEARS OLD)		RELATIONSHIP TO INDIVIDUAL
STREET ADDRESS		
CITY	STATE	ZIPCODE

Part 3: I authorize the following information to be used or disclosed on my behalf (check one box):

☐ all my information, including health and financial information may be disclosed; or
☐ only the following limited information: _____

NOTE: THIS AUTHORIZATION DOES NOT INCLUDE DISCLOSURES OF HIV TEST RESULTS, PSYCHOTHERAPY NOTES, CERTAIN DISCLOSURES REGARDING SUBSTANCE ABUSE TREATMENT, OR ANY OTHER DISCLOSURES THAT WOULD BE INCONSISTENT WITH CALIFORNIA OR FEDERAL LAW.

Part 4: The purpose of my authorization is (check one box):

☐ to disclose the information at my request to the person identified in Part 2; or
☐ for the following purposes: _____

Part 5: If not previously revoked, this authorization will terminate on the earlier of: (check one box)

☐ 1-year from the signature date below; or
☐ upon the following date or event: _____

(form continues on next page)

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF AN INDIVIDUAL'S HEALTH INFORMATION

I have read the contents of this authorization and understand and agree to the use and disclosure of my information as noted above. I also understand this authorization is voluntary and that the person listed in Part 1 will not condition the treatment, payment, or enrollment or eligibility for benefits on signing this authorization. I have the right to revoke this authorization at any time by giving written notice of my revocation to March Vision Care, Inc., Attn: HIPAA Privacy Requests, 6701 Center Drive West, Suite 790, Los Angeles, CA 90045. I understand that my revocation will not affect any action taken before my written revocation notice is received.

I understand that if the organization I have authorized to receive the information is not a health plan or covered entity health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I understand I have the right to receive a copy of this authorization. A copy of this authorization is valid as if it were an original.

Part 6: After reading and completing the form above, please complete one (1) of the signature boxes below:

If you are the individual listed at the top of the page, complete this signature box:

Date: _____ Signature: _____

OR

FOR PERSONAL REPRESENTATIVES: If you are the designated legal representative or guardian of the individual listed at the top of the page, complete this signature box:

Date: _____ Printed Full Name: _____

Relationship to individual listed at the top of the page: _____

_____

Signature: _____