

Authorization

To Release Protected Health Information Concerning An Application to Sight for Life

A. Information About the Disclosure

I authorize disclosure of my health information as described below. I understand that this Authorization is voluntary and that I may cancel it at any time by writing to the person or business providing the information.

1. Individual's Name: _____
2. Social Security Number: _____
3. The health information will be disclosed by: _____

4. The persons entitled to receive the information are members of Sight for Life who make decisions in connection with an application submitted for care by the Foundation.
5. The information will be disclosed during the period beginning with the date of this Authorization and ending on the later of the date:
 - (i) upon which Sight for Life decides that you are (or are not) eligible for services by the Foundation, and if you are entitled to care, what the care will be
6. The information is being disclosed to Sight for Life so it can decide if you are eligible for care by the Foundation.
7. This Authorization is being requested by a health care provider. The provider will not receive payments or other things of value in exchange for disclosing the health information.
8. This Authorization will expire when the period described in paragraph 5 of this form ends.

B. Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may cancel this Authorization at any time by writing to the person or business that is providing the information and telling them I want to cancel. Please note that if you cancel the Authorization, this cancellation will not have any affect on any actions taken before your cancellation notice is received.
- I may see and copy the information described on this form if I ask for it.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by Sight for Life for the purposes described in paragraph 6 of this form. I understand that once this information is given to Sight for Life, it will likely no longer be subject to protection under federal privacy regulations.

C. Signatures

Signature of individual or individual's representative

Date

Printed name of the individual or individual's representative

Representative's relationship to the individual, including authority for status as representative