Authorization to Use & Disclose Protected Information Form
RELEASE FORM
District 2E2 Lions Organ & Eye Bank (LOEB)

Under the HIPAA Privacy Rule, an individual may authorize the release of his or her protected health information (PHI) to a specific person or entity. Please follow the instructions below for completing this form.

- The individual's use of the authorization form is always voluntary.
- You may limit to this release to ONLY the Lions Organ and Eye Bank Board of District 2E2, or specify to which persons/agencies the information may be additionally released.
- You may voluntarily revoke it at any time or set a limited range of time for its validity.

I. **Individual** (Name and information of person whose protected health information is being disclosed):

_____

Name Date of Birth

_____

Social Security Number

_____

Address City State ZIP

( )_____ ( ) _____

Area Code & Home Telephone Business/ Mobile Number(s)

All of the information in Section I pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other individual covered or applying for coverage under the subscriber's membership.

II. Authorization and Purpose:

I request and authorize the LOEB to disclose my protected health and financial information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, this disclosed information may not be released at any time.

_____

Persons/Health Providers/ Organizations authorized to receive your information

_____

PLEASE SPECIFY: (NONE) (ONLY THOSE LISTED)

III. Specific Description of Information to be Used or Disclosed

**NOTE: This Authorization CANNOT be used to disclose Psychotherapy Notes.

Describe Services from (Specify provider or supplier: eg, surgical, sales, examination, training, eyeglasses, etc.)

_____

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

_____One year from the (insert date or event):_____ date it is signed.

Right to Revoke:

I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

V. Signature

(this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____

Signature Date: (month/day/year)

_____

Personal Representative's Name Relationship to Individual
Area Code & Telephone Number/email address

BEFORE RETURNING THIS FORM--KEEP A COPY FOR YOUR RECORDS
Mail to: P.O. Box 830, Fort Worth, TX 76101