**DR. DAVID GALINA**
1581 RT. 202 SUITE 19
PACESETTER PARK
POMONA, NY 10970
845-354-5661

## HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize Eyemagination Optical to use or disclose my health information in compliance to the Health Insurance Portability and Accountability Act of 1966 (HIPAA) Privacy Standards. I understand that I have the right to revoke this authorization, in writing, at anytime, except where uses or disclosures have been made based upon my original permission. I understand that uses or disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Name of Patient: ______________________________ Date of Birth: ________________

Signature of Patient: ______________________________ Date: ___________________

**(Optional)** If the patient is a minor or unable to sign, please complete the following:

Relationship to Patient: ________________________

Signature of Authorized Representative: ________________________

Date: ________________________

**(Optional)** The mentioned party may disclose this health information to the following recipient:

Name: ________________________ Phone Number: ________________________

Prepared by Abyde for:
*Eyemagination Optical*