HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

1 AUTHORIZATION

I, _____, give my permission for **2U Vision, LLC** to share the information listed in Section 2 HEALTH INFORMATION of this document with the person(s) or organization(s) I have specified in Section 4 WHO CAN RECEIVE MY HEALTH INFORMATION of this document.

2 HEALTH INFORMATION

I give the above healthcare organization permission to (check the correct boxes):

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (specify) _____

Form of Disclosure

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

3 REASON FOR DISCLOSURE

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____
_____
_____

4 WHO CAN RECEIVE MY HEALTH INFORMATION

I give authorization for the health information detailed in Section 2 HEALTH INFORMATION of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s) or organization(s) or both listed in this Section 4 WHO CAN RECEIVE MY HEALTH INFORMATION may not be covered by state or federal rules or both governing privacy and security of data and may be permitted to further share the information that is provided to them.

(Over)

5 DURATION OF AUTHORIZATION

This authorization to share my health information is valid: (check the correct box and include the necessary information):

☐ From _____ to _____,

Or

☐ All past, present and future time periods,

Or

☐ The date of the signature in Section 6 until the following event:
_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Paul W. Koda
HIPAA Compliance Officer
2U Vision, LLC
2413 Archdale
West Bloomfield, MI 48324

I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

I understand that I do not need to give any further permission for the information detailed in Section 2 HEALTH INFORMATION to be shared with the person(s) or organization(s) listed in Section 4 WHO CAN RECEIVE MY HEALTH INFORMATION.

I understand that the failure to sign or submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

I have read and understand the entirety of 2U Vision, LLC's Notice of Privacy Practices Effective April 1, 2022 located at https://www.2UVision.com/privacy

6 SIGNATURE

Signature: _____ Date: _____
Printed Name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a Power of Attorney, legal guardian or health care agent, please complete the following:
Name of person completing this form: _____
Signature of person completing this form: _____
Describe legal authority to sign this form: _____