

**AUTHORIZATION FOR THE USE AND DISCLOSURE  
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION  
NYS VISION PLAN**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. By signing this document I understand that I authorize a person or entity to receive information and it may be re-disclosed and no longer protected by federal privacy regulations.

Persons/organizations authorized to use or disclose the information: EyeMed Vision Care

**Complete the following information:**

The persons/organizations you are authorizing to receive the information:
Specific description of information that may be used/disclosed:
This authorization expires on [insert applicable date or event]:

I understand that I may inspect or copy the information used or disclosed. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:

- action has been taken in reliance on this authorization; or
- if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

A copy of this signed form will be provided to the member.

**Complete the following information only if EyeMed Vision Care is requesting the information for its own uses and disclosures:**

The information will be used/disclosed for the following purposes [Check One]:
<input type="checkbox"/> At the Request of the Individual <span style="margin-left: 150px;"><input type="checkbox"/> Other-Please Describe:</span>
The organization authorized to use/discard the information will receive compensation for doing so.
Yes <input type="checkbox"/> No <input type="checkbox"/>
This authorization expires on [insert applicable date or event]:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

**Complete and sign this section:**

Signature of Patient:	Date
Printed Name of Patient:	Patient Date of Birth:
EyeMed MVC Number (located on your ID card) or Enrollee SSN:	