SPECIALTY EYE INSTITUTE

Patient Authorization for Procedure Viewing

Printed Name:_____ Date of Procedure: _____

Date of Birth: _____

I hereby authorize the Facility to allow third parties, including but not limited to prospective patients and the family members and friends of prospective patients, to view my surgery and/or procedure at the Facility. I acknowledge that the third parties' viewing of my surgery(s) may cause my personal and medical information to be disclosed to the viewers and the general public.

I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the Facility and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Unless revoked, this Authorization will expire at midnight on the date of the procedure/surgery.

Re-disclosure
I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipients and no longer protected by Federal or state privacy requirements. Facility, its affiliates, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this Authorization and that my treatment or payment for services will not be denied if I do not sign this Authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative applicable) Relationship of Personal Representative to Patient (if

Neither Facility nor its affiliates are receiving compensation/payment from a third party for use or disclosure of Protected Health Information.

I DO NOT authorize SEI to allow third parties, including but not limited to prospective patients and the family members and friends of prospective patients to view my procedure at SEI. I request that SEI takes all precautionary measures necessary to prevent any viewing of my procedure.

_____ _____
DATE SIGNATURE OF PATIENT OR GUARDIAN

_____ _____
DATE WITNESS/SPECIALTY EYE INSTITUTE REPRESENTATIVE