 

**GARY R. TYLOCK, M.D., P.A.   
HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION AND CONSENT/USE OF PHOTOGRAPHS AND AUDIO/VIDEO IMAGES.**

Gary R. Tylock, M.D., P.A. (Tylock-George Eye Care and the George Foundation for Sight Restoration) is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received at Tylock-George Eye Care. Sharing your story can help others who are interested in knowing more about the patient services provided by Tylock-George and can help promote its mission of excellent patient care to the community.

Tylock-George Eye Care respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Tylock-George seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in Tylock-Georges’ internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines). To ensure that Tylock-George is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Tylock-George Eye Care will keep a copy of your written permission on file.

* I do give my permission for Tylock-George Eye Care and the George Foundation for Sight Restoration to use my name and share details of my treatment and experience as a patient in communications produced by or on behalf of Tylock-George Eye Care/George Foundation for Sight Restoration, and consent to take and make use of my audio/video/photographic images in publications produced by or on behalf of Tylock-George Eye Care/George Foundation for Sight Restoration. This permission extends both to electronic versions of our websites and other internet/electronic applications as well as to printed, filmed, and taped versions.

I am not required to sign this authorization. Tylock-George Eye Care does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time. I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual’s health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Tylock-George Eye Care Privacy Officer at 3100 N. MacArthur Blvd., Irving, TX, 75062. I understand that Tylock-George Eye Care, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Tylock-George Eye Cares’ control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_