Guiding Eyes for the Blind - Release of Medical Information

Request for Authorization to Release Medical Information

Guiding Eyes endeavors to work with our clients to maximize potential for successful pairing with, and use of, our guide dogs. As part of that process, awareness of pertinent pre-existing medical conditions helps provide our professional staff with the opportunity and preparedness to help create a safer working environment and/or prevent/identify client injuries or medical events in the case of conditions such as, but not limited to, diabetes, epilepsy, severe allergies, asthma attacks, bleeding disorder, etc. Having basic knowledge and awareness of client medical information also allows our staff the opportunity to make more precise evaluations on how clients manage their conditions in relation to training/working with a guide dog.

To that end, we ask each client to give us their authorization to release medical information to authorized staff by signing the attached form. If you are willing to consent, please sign and return this form to us. If you are not willing to consent, please so indicate below.

Please understand that your signature and return of this Authorization is voluntary, and while Guiding Eyes retains absolute discretion to define the scope of our programs and determine who participates in them based on our evaluation of client needs and circumstances, we will not condition any acceptance to our programs on whether this authorization is furnished.

First Name _____

Last Name _____

Phone _____

Birthdate - Format: (MM/DD/YYYY) _____

☐ **I agree to provide an authorization and attach a signed copy.**

☐ **I do not agree to provide the requested authorization.**

Signature

_____

Authorization to Release Medical Information

Given pursuant to the
Healthcare Insurance Portability and Accountability Act (HIPAA) and other applicable law

By signing below, I hereby give my permission for the release of health information to authorized personnel of Guiding Eyes for the Blind, Inc. ("Guiding Eyes") as more fully described below, in accordance with HIPPA and other applicable law:

(1) Information to be disclosed and released (the "Information")

All physician reports, medical records, and health information, whether furnished by me or others, including but not limited to observations, summaries, diagnoses, treatment, medications as received, populated in Salesforce or otherwise held or recorded in Guiding Eyes medical/client files or in the custody of Guiding Eyes' Health Services Department. Disclosure may be effected in hard copy, email or electronic form, in such manner as determined to be appropriate by Guiding Eyes Health Services Department personnel consistent with the purpose of disclosure described below.

(2) Identification of those authorized to make the requested disclosure of Information

Any or all Guiding Eyes Health Services Department personnel having custody or control of the Information.

(3) Description of those authorized to receive the Information

Such Regional Guide Dog and Mobility Instructors (RGDMIs) and Placement Specialists working on Guiding Eyes' campus/premises or in the field as have been assigned responsibility by Guiding Eyes to oversee or effect placement of guide dogs with clients, provide training and ongoing advice in connection with client use of guide dogs, and generally supervise or monitor guide dog use and such follow-up as may be required. (such individuals hereinafter referred to as "Authorized Staff Members").

I understand that while Guiding Eyes has, and will put in place such policies, limits and procedures as it deems appropriate, requiring Authorized Staff Members to keep Information confidential, Authorized Staff Members as described above may not be limited by state/federal rules governing privacy and security of data.

(4) Purpose of the disclosure

Disclosure of Information to Authorized Staff Members is for purposes of providing them with the opportunity and preparedness to help create a safer working environment and/or prevent/identify actual or potential client injuries or medical events in the case of such conditions as, but not limited to, diabetes, epilepsy, severe allergies, asthma attacks, bleeding disorder etc. Having this basic knowledge and awareness will also give Authorized Staff Members the ability to make more precise evaluations on how clients manage their conditions in relation to training/working with a guide dog thereby helping minimize problems and maximize potential for success.

(5) Duration of authorization

This Authorization is effective immediately and shall be valid as to all, past, present, and future periods.

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

Guiding Eyes for the Blind, Inc.
Health Services Department
611 Granite Springs Road
Yorktown Heights, NY 10508

Attention: Nurse Manager
E-mail: nursing@guidingeyes.org

I understand that if my Information has already been shared by the time my Authorization is revoked, it may be too late to cancel permission to share my Information. I understand any revocation of this authorization will be effective upon Guiding Eyes' written acknowledgment to you of its receipt, which Guiding Eyes will promptly send to me upon receipt.

I understand that I do not need to give any further permission for the Information described above to be shared with the personnel described above.

(6) Signature and Date

First Name **Last Name**

_____ _____

Signature **Date - Format: (MM/DD/YYYY)**

_____ _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor, or health care agent, please complete the following information:

Name of the person completing this form Date

_____ _____

Describe how this person has legal authority to sign this form

_____