

Permission to Disclose Medical Information

Patient Name

Birth Date

Address

1. I authorize my optometrist to discuss or release health information identifying me to the following individuals/entities:

NAME

RELATIONSHIP TO PATIENT (if any)

NAME

RELATIONSHIP TO PATIENT (if any)

NAME

RELATIONSHIP TO PATIENT (if any)

2. Description of medical information to be produced: MEDICAL & FINANCIAL

3. This authorization is being made voluntarily and at my request.

4. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this authorization at any time by notifying my optometrist in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.

_____ I understand that, unless otherwise revoked, this authorization will expire 365 days from the date entered below.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy law.

I do hereby swear that I have read and understand the above information.

Date

Signature of Patient/Legal Representative

Printed Name of Legal Representative

Description of Relationship to Member

Phone # of Legal Representative

Address of Legal Representative