Vision Professionals

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

The following organization is authorized to make the disclosure:

Vision Professionals

The type of information permitted to be disclosed is as follows:

___Health Records/Exam Results ___Invoice Billing/Insurance Information

___Prescription Information ___Other (please specify)_____

___Consultation Requests _____

I understand that the information in my health record may include information relating to current medications, diseases, and/or information about drug and alcohol use/abuse.

This information may be disclosed to and used by the following individual and/or organization:

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

Organization Name:_____

Address:_____City:_____Zip:_____

Reason for Disclosure:_____

____ I **decline** the disclosure of my health information to any individual and/or organization.

I understand I have the right to revoke this authorization at any time. Unless otherwise revoked, this authorization will expire one year from the date of which it was signed.

Signature:_____Date:_____

Office Representative:_____Date:_____