HIPPA Right of Access Form

☐ I, _____, authorize Seacoast Vision Care to disclose my protected health information including diagnosis, records, and claims information. The following individual(s) may have access to my information:

1. Name: _____Relationship:_____

   Address: _____

   Phone Number: _____

2. Name: _____Relationship:_____

   Address: _____

   Phone Number: _____

3. Name: _____Relationship:_____

   Address: _____

   Phone Number: _____

☐ I do not authorize Seacoast Vision Care to disclose my protected health information to anyone.

This authorization shall be effective until (Check one):

☐ All past, present, and future periods.

☐ Date or event unless revoked: _____

(You may revoke this authorization in writing at any time by notifying Seacoast Vision Care.)

Patient Name: _____ Patient DOB:_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____