# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________________________________________

Patient Date of Birth: ___________________________________

I authorize the disclosure of my personal health information from the person/entity as described below for continuation and coordination of my medical care. I understand this authorization is voluntary and can be revoked at any time in writing, addressed to the contact information listed above. I have the right to determine an expiration date for this authorization. If no date is listed this authorization will be in effect for 1 year or until revoked. Expiration date ____________________.

The information you may release subject to this signed release form is as follows:

- ▫ Complete Record
- ▫ Last Examination Record
- ▫ Specialty Testing Reports
- ▫ Eyewear and Contact Lens Prescription
- ▫ Other (please specify)

_________________________________________________________________

I authorize disclosure from the following person/entity:

Name __________________________________________________

Address __________________________________________________

By signing below, I confirm the release of my information from the entities listed above to Visionary Eye Care, and I attest the information listed is, to the best of my knowledge, current and accurate.

Signature: ___________________________________________ Date: ___________________________

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Personal Representative's Name: __________________________________________________

Description of Personal Representative's Authority: _____________________________________________