PERMISSION TO SEND HEALTH INFORMATION

VISIONcare ASSOCIATES See the best.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone Number ( ) _____

City _____ State _____ Zip _____

SENDER

I authorize:

Name of Clinic _____

Street Address _____ Fax Number ( ) _____

City _____ State _____ Zip _____

RECIPIENT

To share (disclose) my health information with:

Name of Clinic _____

Street Address _____ Fax Number ( ) _____

City _____ State _____ Zip _____

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider

HEALTH INFORMATION TO BE SHARED

☐ Visit Notes ☐ Operative Reports ☐ Laboratory/Pathology Reports

☐ School Physical Forms ☐ Medication List ☐ Glasses and Contact Lens RX

☐ Diagnostic Imaging ☐ Records from a Specific Provider _____

DURATION AND REVOCATION

This authorization will remain in effect for *one year* from the date of the signature below, unless you specify a different date here: _____(date). You or your Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

SIGNATURE

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Printed Name of Patient/Personal Representative Description of Personal Representative's Authority