Jackson Vision
The Eye-deal Choice

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First _____

Address _____

Date of Birth: _____ **Phone #** _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION

FROM: _____
Person/entity authorized to disclose information

_____
Address

_____

_____
Phone/Fax Number

TO: _____
Person/entity authorized to receive this information

_____
Address

_____

_____
Phone/Fax Number

DESCRIPTION OF INFORMATION TO BE DISCLOSE:

____ALL information contained in my medical record (including but not limited to list below)_____
Specify date range, if applicable

OR

____ONLY the specific information:_____

_____

_____

PURPOSE OF THIS DISCLOSURE (CHECK ONE):

____ Continuing care ____ Insurance ____ Legal ____ Disability ____ Patient Request

____ Other (Specify)_____

I ACKNOWLEDGE that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be redisclosed by them and no longer protected by the Privacy regulations

I ACKNOWLEDGE that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I ACKNOWLEDGE that I may revoke this Authorization in writing at any time by contacting the disclosing party (Jackson Vision or other entity) except to the extent that action has been taken in reliance on this Authorization. This Authorization expires one year from date signed.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient)

PROVIDE COPY TO PATIENT (IF APPLICABLE)

Revised 10/21/2014