EYE-Q

Date: _____ Patient: _____

DOB: _____ SSN#: _____

Copies of this signed authorization will be considered as valid as the original.

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. **Failure to provide all information requested may invalidate the Authorization.**

_____ I hereby authorize and request Eye-Q Vision Care to send my medical records to:

Name of persons/provider: _____

_____ I hereby authorize and request my medical records be sent to Eye-Q Vision Care from:

Name of persons/provider: _____

Purpose of use of disclosure:

Continuing care ____ Additional benefits ____ Payment of claim ____ Other ____ (specify below)

_____

This authorization applies to the following information (select only *one*).

_____ All health information pertaining to any medical history, mental or physical condition and treatment received.

_____ Only the following records or types of health information (including any dates):

_____

This authorization will expire **180 days** from the date I sign it as evidenced below, or until _____. I understand that I may revoke this authorization at any time, provided that I do so in writing and deliver the revocation to Eye-Q Vision Care's Privacy Officer or Medical Records Coordinator, 7075 N. Sharon, Fresno, California 93720. My revocation will be effective upon receipt. I may inspect or obtain a copy of the health information that I am being asked to use/disclose. I understand the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signature: _____ Date: _____

Patient/Legal Representative

If signed by someone other than patient, state your legal relationship to the patient.

_____

Signature of Witness: _____ Date: _____