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GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Authorization to Disclose Health Information

Patient Name: _____

SS # _____ Date of Birth: _____

Current Address: _____

1. I hereby authorize Grene Vision Group, LLC, to release / obtain from the person or practice named below any and/or all records regarding the medical history and treatment provided to the above named patient.

Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Fax: _____

Complete Health Record from _____ to _____ Dates of Service
(office visits, testing, prescription items)

OR _____ from _____ to _____ Dates of Service
(Specific record type)

2. Information to be used or disclosed is for the purpose of _____

3. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Grene Vision Group office where my records were obtained. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. This authorization will remain valid unless 1) otherwise revoked, or 2) authorized to expire on the following date: _____

5. I understand I may inspect or copy the information to be used to disclose, as provided in CFR 126.524.

6. I understand any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. If I have questions about disclosure or my health information, I can contact the clinic's Privacy Officer.

Signature of Patient/Guardian or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient