GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Tel _____ Fax _____

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