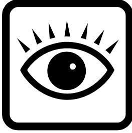

Vision Clinics Inc.

EXCEPTIONAL FAMILY VISION CARE FOR OVER 25 YEARS

TED HILL, OD JAY WARD, OD

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the HIPAA Patient Privacy Policy, this authorization allows Vision Clinics Inc. to release any of your protected ☐ **Medical** ☐**Billing** (check all that applies) information to individuals that you wish to specify.

I hereby authorize Vision Clinics Inc. to release information regarding my medical history and treatment by means of verbal communication via phone or in person, by mail or fax, to the person(s) listed below:

____

Name and Relationship to Patient

____

Name and Relationship to Patient

If it becomes necessary to contact you by phone, please list the number(s) where you wish us to call.

____

Phone number and type of phone line (home, cellular, business, etc.)

May we leave messages, such as lab results, appointment reminders, or other medical information on an answering device, or with another person who answers the phone at that location? ☐ Yes ☐ No

Expiration Date of Authorization

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to (Name of Practice). You should contact the (Title of Privacy/Compliance Officer) to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

____

Name of patient (Print or type)

____

Signature of Patient Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

13404 S. Memorial Dr., Bixby, Oklahoma 74008

918-369-2020 **www.bixbyvision.com** **918-369-8600 fax**