Mountain View EYE CENTER

Authorization for Mountain View Eye Center Disclose My Health Information

Patient Name: _____ Date of Birth: _____

I. My Authorization

Mountain View Eye Center, may disclose the following health care information:

☐ All my health information maintained by Mountain View Eye Center

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):_____

☐ Other:_____

You may disclose this health information to:

Name of Person(s) and/or Organization: _____

Address: _____City _____State _____Zip_____

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____
☐ no end date

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment.

I may revoke this authorization at any time, in writing, sent to Mountain View Eye Center at the address provided below. If I do, it will not affect any actions already taken by Mountain View Eye Center based upon this authorization; uses and disclosures already made cannot be taken back.

Once the office discloses health information, the person(s) or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed name if signed on behalf of the patient | Relationship & Authority (parent, legal guardian, legal representative, etc.)

Patient is unable to sign because of: _____
Age of minor or reason for patient's inability to sign