Kent EYE CLINIC
Vision Source

Patient Authorization to Disclose, Release and/or Obtain Protected health Information

1. **Patient Information**

Name: Last, First, MI

_____

Street Address: _____City: _____ State: _____ Zip: _____

Birthday: _____ Phone Number: _____

2. **Purpose or need for disclosure – may be released electronically (Please check all applicable)**

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) _____

3. Records to be released from:
   - ☐ Kent Eye Clinic
   - ☐ Contact Lent & Dry Eye Center
   - ☐ Other: _____
     _____

4. **Records to be disclosed to (e.g. Insurance Company, Attorney, Physician, Patient)**

Name: _____ Telephone: _____ Fax #: _____

Street Address: _____ City: _____State: _____Zip: _____

5. **Records to be disclosed:**

   - ☐ Comprehensive overview of chart
   - ☐ Images
   - ☐ Other (specify) _____

6. **Authorization is in effect until _____ (date)**

   Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

Signature (Patient Or Person Authorized To Give Authorization) **Date**

_____

If Signed By Person Other Than Patient, Provide Printed Name, Reason Relationship to Patient, Description Of Their Authority

_____

By Signing this page, I acknowledge that I have read and agree tot the terms on this form. Patient Authorization to Disclose, Release or Obtain Protected Health Information.