PERMISSION TO DISCLOSE MEDICAL INFORMATION

Vision Care 4Life
2020 N. Woodlawn, Suite 390
Wichita, KS 67208
Phone: 316-682-9891
Fax: 316-682-9829

_____ _____
Patient's Name Birth Date

_____
Street Address

I authorize my optometrist to discuss or release health information identifying me to the following individuals/entities:

_____
Name of Company

_____
Name of Company

_____
Name of Company

In signing this authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

_____ I understand that, unless otherwise revoked, this authorization will expire 365 days from the date entered below.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy law.

I do hereby swear that I have read and understand the above information.

_____ _____
Signature of Patient or Guardian Date