**(Release of Information to This Office)**

Authorization for Use and Disclosure of Protected Health Information
(PHI) To Ophthalmic Consultants of Vermont

I authorize NAME OF PROVIDER _____
ADDRESS _____
CITY, STATE, ZIP _____

To disclose the following protected health information

TO:_____,M.D.

at

Ophthalmic Consultants of Vermont
55 Timber Lane
South Burlington, VT 05403

This authorization permits my physician(s) to disclose the following individually identifiable health information about me:

_____

_____

This protected health information is being disclosed for the following purposes:

_____

If this request is by the patient, purpose may be listed as "at the request of the individual". The purpose(s) are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I have the right to revoke this authorization in writing to the extent that the practice has acted in reliance upon this authorization.

_____ _____ _____
Signature of Patient or Legal Guardian (if signed by legal guardian, print name) Date

_____ _____
Print Name of Patient Patient Date of Birth

_____ _____
Patient Address Patient City, State, Zip