OPHTHALMIC CONSULTANTS OF VERMONT
VERMONT LASER VISION
VERMONT COSMETIC EYE

RELEASE OF INFORMATION FROM OPHTHALMIC CONSULTANTS OF VERMONT

Authorization for use of disclosure of Protected Health Information (PHI) to Ophthalmic Consultants of Vermont. We provide this for to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize Dr. _____

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

To disclose the following protected health information

TO: _____

ADDRESS: _____

_____

The 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 information.

This authorization will expire on: _____

The above-mentioned Protected Health Information may be subjected to re-disclosure by the party receiving the information and may no longer be protected by privacy rules. By signing this form, you authorize Ophthalmic Consultants of Vermont to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy office of the Practice.

This Request was signed by: _____ _____

Printed Name - Patient or Representative | Signature - Patient or Representative

Relationship to Patient (if other than patient): _____

Patient Date of Birth: _____/_____/_____ Date: _____/_____/_____