



Gregory McCormick, MD • Cataract, Cornea & Refractive Surgery
Katherine Lane, MD • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
David Shiple, MD • Cataract, Cornea & Comprehensive Ophthalmology
Joshua Hardin, MD • Glaucoma, Cataract & Comprehensive Ophthalmology



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 form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize _____, M.D.

at

Ophthalmic Consultants of Vermont
 55 Timber Lane South Burlington, VT 05403
 Phone: (802) 864-2010
 Fax: (802) 864-1218

To disclose the following protected health information:

TO: _____

ADDRESS: _____

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: _____

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 the 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.



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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