



**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 TO 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 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  
 Phone: (802) 864-2010  
 Fax: (802) 864-1218

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.

\_\_\_\_\_



**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



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