OPHTHALMIC CONSULTANTS OF VERMONT

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

VERMONT LASER VISION AT TIMBER LANE

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.

_____	_____	_____
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	