EYECARE EAST PLLC

9031 Valley Crest Lane Germantown, TN 38138
Phone: (901) 757-2020 Fax: (901) 751-2399
eyecareeast@gmail.com

AUTHORIZATION TO OBATIN OR RELEASE HEATLH INFORMATION

Patient Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security # xxx-xx _____

1. With regard to the information identified in Section 3 below, I authorized the physicians of Eyecare East, PLLC to obtain and / or release information from or to the health care provider or organization listed below:

   Doctor or Clinic: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Telephone: _____ Fax: _____

2. This information is being disclosed per the patient's request.
3. I authorized the disclosure of the following information from my medical records:
   - Complete record
   - Progress Notes
   - Contact Lens Information
   - Other: _____
4. I understand that the information I my health record may include information about personal health issues including sexually transmitted diseases, AIDS, HIV or other pertinent information.
5. I understand that I have the right to revoke this authorization at any time by written notice to Eyecare East, PLLC (9031 Valley Crest Lane Germantown, TN 38138), or to the applicable person and / or organization identified in Section 1. I understand this revocation will not apply to information that has already been used or obtained. I understand that the revocation will not apply to my insurance company when the law provided my insurer the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire automatically in six months.
6. I understand that I can refuse to sign this authorization. I need not to sign this form in order to obtain treatment, payment
7. or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may no longer be protected by the federal confidentiality rules. If I
8. have questions about the uses or disclosures of my health information, I may contact Eyecare East, PLLC HIPPA Officer at
9. 9031 Valley Crest Lane, Germantown, TN 38138 and or the person or organization identified in Section 1 above.

_____ _____
(Signature of patient or personal representative) (Printed name of patient or personal representative)

_____ Date: _____
(Relationship to patient if personal representative)
If Personal Representative, the patient is unable to sign because:

- Minor
- Incompetent
- Other (explain) _____