Parker Vision Specialists, P. C.
J. Michael Bell, O.D.
Sarah A. Bell, O.D.
Matthew Albin O.D.

Authorization for Use or Disclosure of Information

I hereby authorize_____

__ use the following protected health information, and/or
__ disclose the protected health information to the following entity:

Information to be used or disclosed (Check appropriate items):
___ Complete Record
___ Exam Notes and Diagnosis - last comprehensive exam only
___ Surgical (operative report, pathology report)
___ Diagnostic Test Results (retinal, corneal, visual fields, etc.)
___Spectacle RX and Contacts **RX**
___Other _____

For the following dates of treatment: _____

• I understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance upon it). Unless revoked or renewed in writing, this authorization will automatically expire 180 days from the date signed below.

• I understand that authorization for disclosure is voluntary and I can refuse to sign this authorization and it will not condition treatment.

If the patient is a minor, subject to a guardianship, I have signed my name below on behalf of the patient and myself:

_____ _____
Signature of Patient or Legal Guardian or Agent Date

_____ _____
Printed Name of Patient Date of Birth

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