

Parker Vision Specialists, P.C.
J. Michael Bell, O.D.
Sarah A. Bell, 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 actions have 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

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