concept EYECARE

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

LAST NAME FIRST NAME DOB

□ I hereby authorize Concept Eyecare, its optometrists and staff to release protected health information

To:

NAME PHONE # FAX #

STREET ADDRESS

CITY STATE ZIP

□ I hereby authorize the name listed below:

NAME PHONE # FAX #

STREET ADDRESS

CITY STATE ZIP

To release the following protected information:

□ Comprehensive eye exam report □ Glaucoma evaluation & testing
□ Visual field tests □ Optic nerve analysis

To: **Concept Eyecare, PLLC** 8315 Preston Rd, Ste 200-D, Plano, TX 75024

The reasons or purpose for this release of information are:

I understand the specific information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data. I also understand this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization will be in force for one year after I sign it.

I have read and understand this consent, and I have signed it voluntarily.

PATIENT OR PARENT/GUARDIAN'S SIGNATURE DATE