AUTHORIZATION FOR USE AND/OR DISCLOSURE OF
PATIENT HEALTH INFORMATION

I understand that completion of this form means that I am giving permission for the uses and disclosure described below.

Please carefully review and complete this form. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize _____
Name of Recipient

_____
Address

_____
City State Zip

To disclose to: **Precision Optometry, 2230 Sunset Blvd, Ste 380, Rocklin CA 95765**
Ph: 916-782-2020 Fax: 916-790-5700

Records pertaining to:

_____ _____
Name of Patient Date of Birth

_____ _____
Adress Phone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____.

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon authorization.

REDISCLOSURE: I understand that the recipient many not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify the records to be disclosed:

Signature:_____ Date:_____

If signed by other than patient, indicate relationship:_____