Visionary Eye Care
16860 Sheridan Parkway, Unit 106, Broomfield, CO 80023-8989
Phone #: 720-598-2020
Fax #: 720-893-9070

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Patient Date of Birth:_____

Patient Address:_____

Patient Phone Number:_____

I authorize the disclosure of my personal health information to the entity as described below. I understand this authorization is voluntary and can be revoked at any time in writing, addressed to the contact information listed above.

You have the right to determine an expiration date for this authorization. If no date is listed this authorization will be in effect indefinitely, or until revoked.

Expiration date _____

I authorize disclosure to the following (Please fax):

Visionary Eye Care
16860 Sheridan Parkway, Unit 106, Broomfield, CO 80023-8989
Phone #: 720-598-2020
Fax #: 720-893-9070

By signing below, I confirm the release of my information to the entity listed, and I attest the information listed is, to the best of my knowledge, current and accurate.

Signature: _____

Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Personal Representative's Name: _____

Relationship to the Patient: _____