Authorization for Release of Contact Lens Parameters

By signing this form I, _____ authorize the release of protected health information described below to (Provider Name & Address) _____

_____

who is now associated with my eyecare.

I authorize the release of the design and brand of contact lenses you have on record that was fit by a previous eyecare provider as well as other healthcare information you have on file related to my contact lens prescription.

Previous eyecare provider (include address): _____

_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or purposes as I may direct.

This authorization shall be in full force and effect until _____(insert date) at which time this authorization shall expire. If no date - expires in two years.

I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name _____DOB_____

Address _____

City _____ State _____

Zip/Postal Code _____

Patient (or legal guardian) Signature: _____Date: _____

Return form by email to info@artoptical.com

ART Optical contact lens, inc.

PO Box 1848 • Grand Rapids, MI 49501-1848

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