Eyes on Broadway Optical
737 Broadway Dunedin, FL 34698-6973
Phone (727) 754-9134
Fax (727) 953-3949

Date: _____

Authorization to Release Protected Health Information (PHI)

Purpose of Disclosure: Continuing Care

Patient Name:_____ **Date of Birth:**_____

Information to be disclosed: **Glasses RX** / **Contact Lens RX**

I hereby Authorize Doctor/Office _____ To Release my medical records.

Address: _____

Phone: _____ Fax: _____

Send ToInformation To: **Email :** Eyesonbroadway2020@yahoo.com
Fax : **(727) 953-3949**

I Understand that:

- This authorization is valid for 90 days after receipt.
- I may refuse to sign the authorization and that it is strictly voluntary.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I may see and obtain a copy of the information described on this form.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient