FAMILY VISION DEVELOPMENT CENTER

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Authorized Disclosure Statement

I authorize the Family Vision Development Center through its physicians and staff, to disclose individually identifiable health information relating to me, which is called "protected health information" (PHI) under the Health Insurance Portability and Accountability Act (HIPPA), including information about my medical condition, medical need, appointments, and billing account information to the individual(s) listed below.

I release the Family Vision Development Center, its physicians and staff, from any claim of breach of confidentiality in connection with the release of such information.

I consent to disclosure of my protected health information to the following family member(s) or person(s):

☐ No one

1. Authorized Person:_____Relationship:_____

   Phone Number:_____(home/cell/work)

2. Authorized Person:_____Relationship:_____

   Phone Number:_____(home/cell/work)

You may leave a message on my voicemail to confirm appointments and report any normal test results.

Number 1:_____ Number 2:_____

Patient's Signature:_____Date:_____
(Or Personal Representative – POA or other legal proof of authorization must be provided.)
This authorization is valid until revoked by me in writing.

AUTHORIZATION FOR CARE

- ✓ I authorize the Family Vision Development Center (FVDC) providers to provide care as they deem appropriate.
- ✓ I authorize FVDC to release protected health information to my insurance company as needed for claims to be processed.
- ✓ I understand that I am responsible for full payment (less any adjustments that FVDC is contractually required to make) within 30 days of receipt of my statement.
- ✓ I authorize payments of all third party payor benefits to FVDC.

_____ _____
Signature Date

PATIENT NAME:_____ **DOB:_____/_____/_____**
(Please Print)