C.R. LAIT OPTICAL & L.W. VISION CARE

A MEMBER OF VISION SOURCE®

DR. SHANNON CLARK LEITENBAUER, O.D., F.A.A.O • DR. KELLY WADDELL, O.D.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FROM C.R. LAIT OPTICAL & L.W. VISION CARE

I authorize the office of L.W. Vision Care (prior health care provider) to release, use, and/or disclose certain protected health information about me to the office of _____.

This information requested is described below.

This information will be used for continued medical care. This authorization will expire thirty days (30 days) from the date I sign this form unless specifically noted otherwise.

I understand that I may revoke this authorization, in writing, at any time, by sending a written request to the prior health care provider, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment from either my prior or current health care provider.

When my information is used or disclosed pursuant to this authorization, it may/will be considered Protected Health Information and subject to federal HIPAA Privacy Rule.

By signing below, I acknowledge that I have read, and I understand this authorization form.

Signature: _____ (Patient/Legal Guardian)

Print Name: _____

Date of Birth: _____ Date: _____

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