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

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

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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