

# 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.

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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: \_\_\_\_\_