



Effective as of 4/14/03

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. By signing this document I understand that I authorize a person or entity to receive information and it may be may be re-disclosed and no longer protected by federal privacy regulations.

- 1. Persons/organizations authorized to use or disclose the information: EyeMed Vision Care
2. The persons/organizations you are authorizing to receive the information:
3. Specific description of information that may be used/disclosed:

Items 4-6 only apply if EyeMed Vision Care is requesting the information for its own uses and disclosures.

- 4. The information will be used/disclosed for the following purposes [Check One]:
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
6. The organization authorized to use/disclose the information will receive compensation for doing so.
7. I understand that I may inspect or copy the information used or disclosed.
8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
9. A copy of this signed form will be provided to the patient.
10. This authorization expires on [upon] [INSERT APPLICABLE DATE OR EVENT]:

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's authority to act for the patient