AUTHORIZATION

Ophthalmology LIMITED

FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

1. Organization(s) or person(s) allowed to release the information indicated by this form:

   _____

   _____

2. Organization(s) or person(s) to receive health information as indicated by this form:

   _____

   _____

3. Specific description of the health information that may be used or disclosed:

   _____

   _____

4. The information will be used or disclosed for the following purpose(s):

   _____ At the request or direction of the undersigned individual.

   _____ For marketing: The disclosing organization ___ will ___ will not receive compensation, monetary or otherwise, as a result of this use or disclosure.

   _____ Other: _____

5. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by the federal privacy regulations.

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

7. I understand that I may revoke this authorization at any time by written notification. However, the revocation is not valid if:
   - Action was previously taken in reliance on this authorization; or
   - This authorization is obtained as a condition for obtaining insurance coverage; other law provides insurer with the right to contest a claim under the policy or the policy itself.

8. This authorization expires:_____ One Year:_____ Other:____/____/____

Patient Name (print): Date of Birth:

_____ _____

Name of Representative: Relationship to Patient:

_____ _____

Signature of Patient or Personal Representative: Date:

_____ _____