KALAMAZOO OPHTHALMOLOGY, P.C.
AUTHORIZATION FORM

Patient Name ________________________ **Date of Birth**:______________

Specific description of the information to be used or disclosed, including the specific purpose: **Any eye related information.**

Individuals who may receive and use the disclosed information:

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Expiration date of this authorization: NONE UNLESS OTHERWISE SPECIFIED

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Signed by:____
Patient or Representative

Relationship to Patient (if other than patient):______________________________

Date Signed : ______________________________

Witness:______________________________Date:_______________________