

CONSENT FOR THE RELEASE OF HEALTH & BILLING INFORMATION

I give my permission for the following persons to speak with Colorado Eye Care regarding my information:

(CIRCLE HEALTH BILLING OR BOTH)

1) _____ Relationship _____ Health Billing Both
Phone# _____

2) _____ Relationship _____ Health Billing Both
Phone# _____

3) _____ Relationship _____ Health Billing Both
Phone# _____

Patient Signature

Date

I hereby give my permission to Colorado Eye Care to request prescription history from my pharmacy for the purpose of providing direct health care services.

DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS (PHYSICIANS)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA, I hereby authorize Colorado Eye Care to disclose the following protected health information to:

____ **Copies of Medical records and results of relevant diagnostic or laboratory tests**

(LIST THE NAMES OF ANY PHYSICIANS THAT IF REQUESTED, YOU WOULD LIKE YOUR RECORDS SENT TO)

1) _____

2) _____

Patient Signature

Date