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#__________________________________

Print Name: **Patient Signature:** **Date**

THIS AUTHORIZATION EXPIRES ON:__________________________________
FUTURE 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.**

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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) ____

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Patient Signature **Date**