Patient Authorization to Disclose Protected Health Information

I,_____, understand Vision Source of Texarkana is authorized by me to disclose my personal "Protected Health Information" in the manner(s) that I have checked below and to the individuals that I have listed below.

I wish to be contacted in the following manner (check all that apply):

□ Home Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Work Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Cell Phone:_____
- □ Ok to leave message with detailed information
- □ Leave message with callback number only

□ Written Communication:
- □ O.K. to mail my home
- □ O.K. to mail to my work/office
- □ O.K. to fax to this #_____

□ Other:_____

Vision Source of Texarkana is authorized by this signed form to disclose or discuss my "Protected Health Information" with the following named individuals:

Name & Relationship

_____ □ Medical Information □ Appt □ Product Pick-Up
_____ □ Medical Information □ Appt □ Product Pick-Up
_____ □ Medical Information □ Appt □ Product Pick-Up
_____ □ Medical Information □ Appt □ Product Pick-Up
_____ □ Medical Information □ Appt □ Product Pick-Up
_____ □ Medical Information □ Appt □ Product Pick-Up

I understand that I have the right to revoke any individual listed on this authorization. That request must be made in writing before that request can be processed. This process can take up to three (3) days once received by our office.

I fully understand and accept the terms of this authorization.

Patient Signature:_____Date:_____

Office Use Only: □ Completed by:_____Date:_____