SHORELINE OPTOMETRY
Ronald G. Seger, O.D., F.A.A.O.
Jenifer Webb, O.D.
419 N. Shoreline Blvd., Mountain View, CA 94043
Phone: 650-967-5789 Fax: 650-967-4106

Authorization to Use or Disclose Health Information

Patient Name: ________________________________ Date of Birth: _______________________

I authorize (Name) ___________________________(Address)___________________________

to disclose my health information, as described below:

1. Description of health information that may be used and/or disclosed:

____

____

2. Send to: Shoreline Optometry
419 N. Shoreline Blvd., Mountain View, CA 94043
Phone: 650-967-5789 Fax: 650-967-4106

3. The purpose(s) for which the information will be used or disclosed.

____

4. I understand that I may revoke this authorization in writing at any time by sending a written request to _________________, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed the information would no longer be protected by the federal privacy rule.

5. This authorization shall expire on____

By signing below, I acknowledge that I have read and I understand this authorization form.

____ ________________

Signature of Patient or Patient's Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act for the patient:

Representative's Name: ____

Representative's Authority: ____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE