InSight Vision Center

Offices at the California Eye Institute
1360 East Herndon, Suites 103 & 201
Fresno, California 93720
(559) 449-5050
(559) 432-2632-fax

Office at Chestnut
7015 North Chestnut, Suite 101
Fresno, California 93720
(559) 492-3547
(559) 478-4345-fax

www.InSightVisionCenter.com
info@insightvisioncenter.com

Copies of this signed authorization will be
Considered as valid as the original.

DATE: _____
PATIENT:_____
DOB: _____

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. Failure to provide all information requested may invalidate the Authorization.

____ I hereby authorize and request **InSight Vision Center** to send my medical records to:
Name of persons/provider:_____

____ I hereby authorize and request my medical records be sent to **InSight Vision Center** at
1360 E. Herndon Ave. Suite 201, CA 93720 or by fax to (559) 432-2632
From: Name of Persons/Provider_____

Purpose of use of disclosure:

Continuing Care ____ Additional benefits ____ Payment of claim ____ Other ____ (Specify Below)
_____

This authorization applies to the following information (Select Only One):

____ All health information pertaining to any medical history, mental or physical condition and treatment received.

____ Only the following records or types of health information (including any dates):
_____
_____

This authorization will expire 180 days from the date I sign it as evidenced below or until:
_____
_____

I understand that I may revoke this authorization at any time, provided that I do so in writing and deliver the revocation to InSight Vision Center's Privacy Officer at: 1360 E. Herndon Ave., Suite #201, Fresno, CA 93720. My revocation will be effective upon receipt. I may inspect or obtain a copy of the health information that I am being asked to use/disclose. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signature:_____ Date:_____

If signed by someone other than the patient, state your legal relationship to patient: _____

Signature of Witness: _____ Date: _____