Anne Meccariello, OD Michael Caplan, OD Courtney Shay, OD Tim LaFreniere, OD

Kathryn Huebner, OD

## AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Street Address: City: State:   Zip:	A.	Patient Name:		Date of Birth:	
City:		Last 4 of Social Security:		Phone Number:	_
B. lauthorize Virginia Eyecare Center to:    Receive information to:   Name:   Address:   City:   State:   Zip:   Phone Number: (		Street Address:			
Receive information to:   Name:			state:	Zip:	
Name:   Address:   State:   Zip:   Phone Number:   Fax Number:   Fax Number:   Address:   Zip:   Phone Number:   State:   Zip:   Address:   Zip:   State:   Zip:   State:   Zip:   Address:   Zip:   State:   Zip:   Phone Number:   Phone Number:   Fax Number:   Zip:   Phone Number:   Phone Number:   Fax Number:   Discharge Instructions   Phone Number:   Phone Number:   Pax Number:   Phone Number:   Pax Num	В.				
Address:   City:					
City: State: Zip:					
Phone Number:		Address:			
Receive information from:   Name:   Address:   Zip:   Phone Number:   Pax Number:   Zip:   Phone Number:   Pax N		City:	State:	Zip:	
Name:   Address:   Zip:   Phone Number:   State:   Zip:   Phone Number:   Fax Number:   State:   Zip:   Phone Number:   State:   Zip:   Phone Number:   State:   Zip:   Phone Number:   State:   Zip:   Phone Number:   State:   State:   Zip:   Phone Number:   State:   State			_ Fax Numbe	er: ()	
Address: City:					
City:					
Phone Number: (		Address:		7'	
C. Purpose of Disclosure:  Date(s) of Service and specific information to be disclosed:    Chara Summary		City:	State:	Zip:	
D. Date(s) of Service and specific information to be disclosed:    Exam Summary	~		_ Fax Numbe	er: ()	
Exam Summary		Purpose of Disclosure:			
E. This authorization will expire:   60 days from date of signature   Other (specify)   F. Fees (Virginia Eyecare Center use only):  1. Prescription copies and copies of medical records sent directly to a physician or optometrist will be provided at no charge.  2. A fee will be charged to the patient or patient's personal representative as follows:    Patient record   \$15	D.				
E. This authorization will expire:   60 days from date of signature   Other (specify)		☐ Exam Summary ☐ Test Reports ☐ F	Prescription(s)	☐ Discharge Instructions	
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		hael Caplan, OD		Email: Eyes@Virgi	niaEyecare.com

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