COURTNEY SHAY, OD
TIM LAFRENIERE, OD
KATHRYN HUEBNER, OD
MALLORY CRANMER, OD, FAAO
BRYAN PROCOPIO, OD
JEN WEIGEL, OD, FAAO

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Releasing records to the patient or guardian

A. Patient Name: _____ Date of Birth: _____

B.

Last 4 of Social Security: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

C. I authorize Virginia Eyecare Center to:

☐ **Release medical information to:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

D. Purpose of Disclosure: _____

E. Date(s) of Service and specific information to be disclosed:

☐ Whatever the doctor determines is necessary to properly transition your care (recommended)

☐ Other(Specify): _____

F. This authorization will expire: ☐ 60 days from date of signature ☐ Other (specify)_____

G. Fees (Virginia Eyecare Center use only):

Records via the patient portal: $10
Family Records via the patient portal: $20
Paper Records: $20
Family Paper Records: $30

H. Statement of Understanding:

- I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand and acknowledge that this authorization extends to use and/or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed.
- Virginia Eyecare Center will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization.

× _____ × _____
Signature of Patient or Person Authorized to Consent — Date Signed

× _____ × _____
Printed Name — Relationship, If not the patient

Thank you for your cooperation.

Virginia Eyecare Center
9314-A Old Keene Mill Road Burke VA 22015

Phone: (703) 569-3131 Fax: (703) 451-9291
Email: Eyes@VirginiaEyecare.com