# Alaska Eye Care Centers, APC

Authorization To Use and/or Disclose Heath Information

Patient's Name (Please Print)_____

Address:_____

City:_____State:_____Zip Code:_____

Phone Number: (  ) _____Date of Birth:_____SSN:_____

I, authorize records **FROM**:_____

_____

To use and/or disclose my health information as identified below **TO**:
Name:_____

Address:_____City:_____State:_____Zip_____

Phone number:(  ) _____

By initialing the spaces below, I authorize the use or disclosure of my health information:

(  ) Complete copy of my medical records **or FROM: (DATE)**_____ **TO: DATE)**:_____

(  ) Copy of Spectacle Rx

(  ) Copy of Contact Lens Rx

(  ) Billing Statements

(  ) Other (please list)_____

*Unless revoked, this authorization will expire 320 days from the date of signing or upon*

*(insert date):_____. Except to the extent that action has already been taken in reliance upon the authorization, I, understand that I may revoke this authorization at any time by giving written notice to Alaska Eye Care Centers, APC.*

*I, have read and understand this form. I am signing it voluntarily. I, authorize this disclosure of my health information as described in this form.*

Patient's Signature:_____ Date:_____

Picture ID #:_____ AECC Representative Name:_____