Authorization to Use and/or Disclose Health Information

Anchorage: Phone: (907) 272-2557 Fax: (907) 274-4932
Wasilla: Phone: (907) 376-5266 Fax: (907) 373-1887

Patient's Name (Please Print)_____

Address: _____

Phone Number: _____ Date of Birth: _____

I, authorize records **FROM**:

_____

_____

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

Name: _____

Address: _____

Phone number: _____ Fax Number _____

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

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

( ) Copy of Spectacle Rx

( ) Copy of Contact Lens Rx

( ) Billing Statements

( ) Other (please list) _____

Unless revoked, this authorization will expire 365 days from the date of signing. 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: _____