Colorado Family Eye Centers
Children's Eye Physicians
Colorado Center for Eye Alignment

Phone 303-456-9456 Fax 303-467-0145 www.cepcolorado.com

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be disclosed:

- ☐ Appointment Date/Time/Location
- ☐ Diagnosis
- ☐ Medications
- ☐ Test Results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ Financial
- ☐ Glasses/Contacts Prescriptions
- ☐ Other (please specify)

_____

Patient Name: _____

Date of Birth: _____

Disclose information to:

Name: _____ Date of Birth: _____

Relationship to Patient: _____Phone Number: _____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (specify expiration date)

☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving Children's Eye Physicians, Colorado Family Eye Center, and Colorado Center for Eye Alignment the right to discuss my medical information with the person/s above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclose by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

Signature: _____ Date: _____

Relationship to Patient (If signed by personal representative of patient) _____