BROOME VISION
DAYTONA EYE CENTER

Patient Name:_____Chart #_____

Date of Birth_____/_____/_____ Email Address:_____

I, _____hereby authorize and request_____to

release my Protected Health Information (PHI) to:

Broome Vision/ Daytona Eye Center
701 S. Ridgewood Ave
Daytona Beach, FL 32114
PH (386) 253-5999
FX (386) 253-1193
DaytonaEyeCenter@Yahoo.com

In addition to the authorization for release of my PHI described above, I furthermore acknowledge that I have the right to authorize access and disclosure of my PHI to anyone of my choosing. I understand that in order for anyone other than myself to pick up my glasses, contacts, prescriptions and/or chart information, I must have them listed below.

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

I request the following restriction (s) to releasing my PHI:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective that any person or entity has ALREADY acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the issuer has the legal right to contest a claim.
Unless otherwise revoked this authorization shall be in force and effect one year from today's date, at which time this authorization expires.

_____

Signature of Patient/Guardian Print Name Today's Date