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Patient Authorization for the Disclosure of Protected Health Information

Printed Name of Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Maiden Name or Other Name used for Records: _____

I hereby authorize (please print):

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

To release to:
Dr. James Jury of Jury Eye Care and/or Dr. Lauren Tatlock of Jury Eye Care

The following information from my records:

☐ Last Eye Exam, including most recent test results

☐ Records from time period _____ to _____

☐ Complete Medical History (if over 10 pages, please mail)

This released information is disclosed for the purpose(s) of: _____

_____

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

The staff and Optometrists, Dr. James Jury and Dr. Lauren Tatlock, of Jury Eye Care are not responsible for the completeness, legibility or omitance caused by the copying of any medical records from another institution.

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____ _____
Printed Name of Patient's Legal Representative — Relationship to Patient

_____ _____
Signature of Witness — Date