COASTAL
VISION CENTER
A Professional Optometry Corporation

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Authorization for Use and Disclosure of Medical Information

This authorization for use or disclosure of my health information is required by state and federal law.

_____ _____
Name Date of birth

_____ _____
Daytime phone number Last four of SSN

I hereby authorize Coastal Vision Center to release information (past, present, and future) regarding my medical history and treatment by means of verbal communication via phone or in person, by email, mail or fax to the person listed below.

_____ _____
Name Relationship to the patient

_____ _____
Phone number Fax number

_____
Email

By signing this form, I authorize Coastal Vision Center to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person listed people. I understand that if I would like to revoke this authorization at any time it must be done in writing.

_____ _____
Signature Date