VISION SOURCE™
HARBOR EYECARE CENTER

161 DEER STREET
PORTSMOUTH, NH 03801
PHONE: 603-430-0211
FAX: 866-694-2132

AUTHORIZATION FOR THE RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. PATIENT INFORMATION (Please Print Clearly):

NAME: _____ DOB: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

B. I AUTHORIZE HARBOR EYECARE CENTER TO **RELEASE/RECEIVE** (Please Circle One) MEDICAL INFORMATION **TO/FROM** (Please Circle One):

NAME: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

OFFICE PHONE: _____ FAX: _____

C. STATEMENT OF UNDERSTANDING:

- I may revoke this authorization at any time in writing to the provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.
- Federal regulations will no longer apply to the information disclosed, and that the provider receiving this information may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of the authorization may be utilized with the same effectiveness as an original.
- This authorization is valid for 365 days from date signed.

PATIENT OR REPRESENTATIVE SIGNATURE:

_____

PATIENT OR REPRESENTATIVE PRINTED:

_____

RELATIONSHIP TO PATIENT:

_____

DATE: _____