



Superior Eye

HEALTH & VISION THERAPY CENTER

2822 Venture Drive | Marquette, MI 49855 | phone: 906.228.4401 | fax: 906.225.0460 | superioreye@hotmail.com

Dr. Heidi Johnson, OD, FCOVD ~ Dr. Jessica Hartwig, OD ~ Dr. Jessica Jackson, OD ~ Dr. Stephan Herman, OD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I authorize the use and disclosure of my health information as described below:

FROM:

Name: _____

Address: _____

FAX: _____

TO:

Superior Eye Health Center

2822 Venture Drive

Marquette, MI 49855

Fax (906)225-0460

Purpose for Release:

Continuation of Treatment Billing Information Disability Determination Other

Specific Information to be Disclosed:

Office/Progress Notes Lab Reports Procedure Reports Contact Lens/Spectacle Prescription

Other: _____

Date or Event when Authorization Expires: _____

I understand that I have the right to revoke this authorization, in writing, at anytime, except (1) where uses or disclosures have already been made based on my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards. I understand that Superior Eye may not condition treatment on my signing this authorization and that I have the right to refuse this authorization. To revoke this authorization, I must do so in writing and send it to Superior Eye Health Center; 2822 Venture Drive, Marquette, MI 49855

Signature of Patient (or Guardian) _____ **Date** _____