Dr. Philip L. Nicholson, O.D.

Independent Doctor of Optometry | Costco Optical | Phone & Fax: (301) 595-9041

PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete all items. An incomplete request may result in delay of release of records. Please Print

Printed Name of Patient Representative	 and Relationsh	nip Pati	ent Representa	ntive address and phone number	
Signature of Patient or Patient Represer	ntative	Date	9		
I, the undersigned, have read the above and a treatment is not conditioned upon the execut I understand that if the person or entity that regulations, the information described above I understand that I may revoke this authoriza extent that action has been taken in reliance or hand-delivering written notification to Dr.	tion of this auth receives the information may be re-disclition at any time upon it or excep	orization. ormation is not a healtl losed and no longer pro by providing a written	n care provider on tected by those notice to the pe	or health plan covered by federal privac regulations. rson identified below except to the	
This authorization will expire one year from t time this authorization to use or disclose the					
Other					
Patient personal use					
What is the purpose of the use/disclosur	re: Changing	; providers – permanen	t transfer of care	Yes No	
Complete Medical History					
Records from time period		to			
Last Exam; Including most recent test:		н, етс)			
The following information from my records:					
Address of person or place records are to be			301-595-90 Fax #)41	
Name of person or place records are to be sent to					
Dr. Philip Nicholson, O.D.			301-595-90	041	
To release to: Please send via		☐ Other	-		
Address of person or place records are reque	Fax#				
Name of person or place records are requested.	ad from		Phone #		
Maiden Name or other name used for record	S				
		Jiate	Σίρ	riidile	
Street Address	City	State	Zip	Phone	
Name of Patient			Date of Birth		