HERITAGE Eye Care

Dr. Dan Yoakum, O.D. P.A.
Dr. Blair Stone, O.D.
Dr. Aleshia Luu, O.D.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

PATIENT D.O.B.: _____

RECORDS REQUESTED FROM:

DOCTOR AND/OR PRACTICE: _____

PHONE/FAX: _____

By signing below I authorize all listed individuals and/or practices to disclose the following Protected Health Information to Heritage Eye Care, Dan Yoakum O.D., P.A.

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke the authorization at any time by notifying, in writing, the above-named doctor and/or medical practice prior to their receipt at the revocation.

This authorization expires within two years unless noted on this form otherwise.

SIGNATURE: _____

DATE: _____