Thomas R. Kroll, O.D., Chrt.
D. Cory Rath, O. D., P.C.
Spencer Quinton, O.D., Inc.

Name (PRINT) ____

Signature on file

I have been provided copies of the office *office policy*, *contact lens guarantee program, and HIPAA privacy policy*. I have read these documents and understand them.

Office Policy

X Signature____Date________________

Contact Lens Guarantee Program

X Signature____Date________________

HIPAA Privacy Policy

I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices***.**

X Signature____Date________________

If signing as a personal representative of the patient, describe the relationship to the patient

Relationship to Patient ____

Patient Disclosure Request

If you would like someone else to have access to your medical records please complete this portion.

I authorize the professional office of my optometrist to release health information about me under the following terms and conditions:

1. ☐ any and all information ☐ restricted information as described __________________________.

2. Information may be released by ☐ fax ☐ mail ☐ verbally ☐ personally ☐ all

3. To whom may the information be released, ____.

If you sign this authorization, you can revoke it later. The exceptions to this are if we have already acted in reliance upon the authorization. If you want to revoke you authorization, send us a written note telling us that your authorization is revoked.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature____Date________________