Dr. Aleksandra Wianecka O.D.

66 Deer Park Ave

Babylon, NY 11702

631-789-6103

Authorization for Disclosure of Protected Health Information (PHI)

(In accordance with HIPPA Regulations)

I Authorize the Doctors of Vision For Life Corp. to release my medical records, test results, and any information pertaining to my medical care to:

(Please Check)

Physicians: **Yes_____** **No_____** **Specific: _____**

Hospitals: **Yes_____** **No_____**

Family Members **Yes_____** **No_____** **Specific: _____**

_____

Insurance Company **Yes_____** **No_____**

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time be sending a written notification to the address below. I understand that a revocation is not effective in cases where the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used to sign this authorization and that my treatment will not be conditioned on signing.

For Office Use Only

Reviewed By: _____Date: _____ **<2016>**

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Patient Printed Name: _____ Date: _____

Patient Signature: _____

Or

Signature of Patient Representative: _____ Relationship: _____

(Please submit proper documentation of authority)

For Office Use Only

Reviewed By: _____Date: _____