AccuVision Optometry

Dr. Joy Michelsen & Dr. John Michelsen

As required by the health information portability and accountability act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our notice of privacy practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described on the backside of this form. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to review you information to complete the sections detailing the information to be released and the purposes for disclosure.

I have read and understood the paragraph above.

Initials_____

Records Release on Back

2580 Old 1st Street • Livermore, CA 94550 •
Phone: (925) 449-8188 • Fax (925) 449-1818
accuvision.optometry@gmail.com • www.AccuVision2020.com

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF
PATIENT HEALTH INFORMATION

I hereby authorize:

_____
Name of Party

_____
Address

_____ _____ _____
City State Zip

_____ _____
Phone Number Fax Number

To disclose to:

AccuVision Optometry
Dr. Joy Michelsen &
Dr. John Michelsen
2580 Old 1st Street
Livermore, CA 94550
Phone: (925) 449-8188 * Fax (925) 449-1818

Patient Health Information Pertaining To:

_____ _____
Name of Patient Date of Birth

_____ _____ _____ _____
Address City State Zip

_____
Phone Number

Revocation: I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.
Re-disclosure: I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.
Duration: This authorization is effective now and will remain in effect until one year after the date signed below.

Specify Records:
☐ A copy of my medical eye records only.

☐ A summary of my diagnosis and treatment.

☐ Other Health Information: _____

A copy of this Authorization is as valid as the original. Patient has a right to a copy of this authorization.

_____ _____ _____
Signature Date Relationship if signed by other than patient.