CORNEAL
CONSULTANATS
OF INDIANA

Price Vision Group

www.pricevisiongroup.com

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

- ☐ Appointment Date / Times
- ☐ Diagnosis Exam Results
- ☐ Medications
- ☐ Lab Test / Results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ Other (specify): ________________________________

Indicate Confidential Information

- ☐ Mental Health
- ☐ HIV Information
- ☐ Alcohol / Drug Information

Patient Name: ____ Date of Birth ______/______/______

Information to be given to: Name: ____

Relationship: ____

Address: ____

Phone: ____

This authorization shall remain in effect from the date signed below until (PLEASE CHECK ONE):

☐ ________________ (specify expiration date or event)

☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Price Vision Group the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature:____ Date: ___________________________

Relationship to Patient (if signed by person representative of patient): ___________________________