FIRSTSIGHT VISION SERVICES, INC.

FIRSTSIGHT VISION SERVICES, INC.
AUTHORIZATION

Effective __________________ [date], I, _____________________________ [Patient's name], hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. I authorize the following organizations or individuals to use or disclose my health information: [check one]

   - ☐ FirstSight Vision Services, Inc.
   - ☐ ____________________________________, O.D. [insert name]
   - ☐ ____________________________________, M.D. [insert name]
   - ☐ Other: [describe]____

2. I authorize the following organizations or individuals to receive my health information:

   - ☐ FirstSight Vision Services, Inc., at the following address:
     ____
     ____
   - ☐ ___________________________, O.D. [insert name] at the following address:
     ____
   - ☐ ___________________________, M.D. [insert name] at the following address:
     ____
   - ☐ Other: [describe] ____
     at the following address: ____

3. Specific description of information that may be used/disclosed:

   ____
   ____
   ____

[see next page]

4. The information will be used/disclosed for the following purposes [**all** purposes must be listed and described]:

Purpose 1

____

____

Purpose 2

____

____

☐ *[check if applicable]* I have initiated this authorization and do not wish to provide a statement of the purpose. The use or disclosure is at my request.

5. I understand that this authorization is voluntary, and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or to be eligible for benefits.

6. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. The revocation will not be valid, however, if:

    a) The entity to which I am providing my authorization has taken action in reliance on this authorization; or
    b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. This authorization expires on [upon] ______________________[insert applicable date or event].

________________________________ **-or-** ___________________________________

Signature of Patient | Signature of Personal Representative of Patient

_____________________ ___________________________________

Date Signed | Relationship of Personal Representative to Patient

----

[TO BE COMPLETED BY FIRSTSIGHT ASSOCIATE]
(check one)

- ☐ I know the individual making this request.
- ☐ I hereby verify the identity of the individual requesting protected health information and the authority of the individual to have access to the protected health information.

______________________________ ____________ ______________________

Signature of FirstSight Associate Date Store Number

For FirstSight Vision Services, Inc. Use Only:

Date Received: (MM/DD/YY) _____/_____/_____

Fee Charged for fulfilling this Request (if applicable): $_____________________

Name or Initials of FirstSight Associate processing this Request: _____________________________________

TO BE PLACED IN FILE OF CUSTOMER