Cardinal Vision LLC
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Cardinal Vision LLC

Dr. Gavin Davis

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____/_____/_____

By signing below, I authorize Cardinal Vision LLC, (CV) to use or disclose information about me [Or anyone I have the authority to sign for] that is protected under federal law, for the reason(s) and time period described below.

Information that **can** be used by or disclosed to CV: [please circle]

All Medical Information (to include billing) **Labs or Other Testing Only** **Billing Only**

Other (please explain)_____

Information that **cannot** be used by or disclosed to CV [please circle]

All Medical Information (to include billing) **Labs or Other Testing Only** **Billing Only**

Other (please explain)_____

Name of the person(s) or class of persons authorized to make the requested use of disclosure and to whom Cardinal Vision LLC may make the requested use or disclosure: [please print]

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

Expiration date or an expiration event (in relation to the individual listed above): [please write in and/or circle]

Expiration Date _____/_____/_____ **Death** **Transfer of Service to a Non-CV Provider**

By signing below, I acknowledge that the protected health information used or disclosed under this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. I understand that CV will not condition treatment based on this authorization and that I have the right to refuse to sign the authorization.

_____ _____/_____/_____
Signature of Patient or Authorized Representative Date

_____
Name of Patient or Authorized Representative (please print)