Cardinal Vision LLC
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Dr. Gavin Davis

Cardinal Vision LLC
Authorization for Release of Health Information

Patient Name: _____ DOB: _____

☐ I wish to release records of above patient **OR** ☐ I wish to release records of above patient
To Cardinal Vision LLC FROM: **From Cardinal Vision LLC TO:**

Doctor / Clinic / Facility / Other Recipient: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Purpose: ☐ Consult / referral ☐ Transfer / continuity of care ☐ Other (specify)_____

Type(s) of records requested (check all that apply):
☐ Office Visit Notes ☐ Operative Reports ☐ Biometry ☐ All
☐ Visual Fields ☐ Diagnostic Imaging ☐ Lab Results ☐ Billing Information
☐Other_____

Dates of Service: ☐ Last visit only ☐ Last ____ visits ☐ Previous ____ years ☐ Other
Restriction regarding released information (if applicable): _____

This authorization permits Cardinal Vision LLC to use and disclose my health information to carry out treatment, payment, and/or healthcare operations. Additional information regarding the uses and disclosures of health information is described in our Notice of Privacy Practices, which is available to review prior to signing this authorization. A patient has the right to request restriction on the use and disclosures of health information, but Cardinal Vision LLC is not required to agree to such a request for restrictions. Unless restricted above, this is an authorization for full release, including information regarding behavioral/mental health, substance abuse treatment, genetic information, HIV/AIDS status, sexually transmitted and other communicable diseases.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that upon release of my information, the recipient might not be bound by federal and state privacy regulation. I hereby legally release and hold harmless Cardinal Vision LLC, its employees, its staff, and its agents in connection with this authorization.

NOTE: A fee may be charged for reproducing records.

_____ _____
Signature of Patient/Parent/Guardian/ Authorized Representative Date:

_____
Print Name (indicate relationship to patient if applicable