Superior Eye
HEALTH & VISION THERAPY CENTER

2822 Venture Drive
Marquette, MI 49855
Phone:(906)228-4401
Fax: (906) 225-0460

Dr. Heidi Johnson OD, FCOVD
Dr. Jessica Jackson OD
Dr. Stephen Herman, OD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ **DOB:**_____

I authorize the use and disclosure of my health information as described below:

FROM:	**TO:**
Name:_____	**Superior Eye Health Center**
Address:_____	**2822 Venture Drive**
_____	**Marquette, MI 49855**
FAX:_____	**Fax (906)225-0460**

Purpose for Release:

[ ]Continuation of Treatment [ ]Billing Information [ ]Disability Determination [ ]Other

Specific Information to be Disclosed:

[ ]Office/Progress Notes [ ]Lab Reports [ ]Procedure Reports [ ]Contact Lens/Spectacle Prescription

[ ] Other:_____

Date or Event when Authorization Expires:_____

I understand that I have the right to revoke this authorization, in writing, at anytime, except (1) where uses or disclosures have already been made based on my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards. I understand that Superior Eye may not condition treatment on my signing this authorization and that I have the right to refuse this authorization. To revoke this authorization, I must do so in writing and send it to Superior Eye Health Center; 2822 Venture Drive, Marquette, MI 49855

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Signature of Patient (or Guardian) **Date**