VALLEY VIEW OPTOMETRY

Name _____ Date of Birth _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

E-Mail _____ ID or SS# _____

Preferred Name _____ Preferred Method of Contact Text Call Email

Responsible Party _____

Address _____

City _____ State _____ Zip _____

Employer _____ Position _____ Phone _____

Spouse's Employment _____ Position _____ Phone _____

Date of last visual examination _____

Whom may we thank for referring you to this office? _____ Relation: _____

Family members still living at home:

Spouse _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the disclosure of my personal health information to the person/entities as described below. I understand this authorization is voluntary and can be revoked at any time in writing, addressed to the contact information listed above.

You have the right to determine an expiration date for this authorization. If no date is listed this authorization will be in effect indefinitely, or until revoked. Expiration date _____

I authorize disclosure to the following people/entities:

1. Name _____

2. Name _____

By signing below, I confirm the release of my information to the entities listed, and I attest the information listed is, to the best of my knowledge, current and accurate.

Signature _____ Date _____

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Personal Representative's Name _____

Relationship to the Patient _____