Wang Vision Institute

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I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

   Dr. 's Name: _____

   Clinic Name (if applicable): _____

   Address: _____

   _____

2. The following person of class of persons may receive disclosure of protected health information about me:

   Dr. 's Name: _____

   Clinic Name (if applicable): _____

   Address: _____

   _____

3. I authorize release of the following information to the above party:

   _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulation.

5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action that already has taken place in accordance to this request prior to my written revocation cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sing the authorization.

6. This authorization expires on _____ or upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of the information about me: _____

This form must be fully completed before signing:

_____

Signature of Individual/Guardian Date DOB