Viewmont Eye Associates
Authorization for Release of Information-Compound Release

Name of Patient_____ Date of Birth_____

Viewmont Eye Associates is authorized to release protected health information about the above named patient in the following manner and to persons indicated.

I wish to be contacted in the following manner (check all that apply):

All appointments, order notifications (glasses, contacts, Rx's) will be confirmed/notified by telephone call, Email, secure messaging (patient portal) or text.

□ Primary Phone or Cell Phone
□ Work Telephone
□ Written Communication
□ E mail
□ Secure Messaging (patient portal)
□ Other_____

I allow you to give my clinical and financial information to or answer questions from (check all that apply and list names):

□ Spouse: _____

□ Parent: _____

□ Child: _____

□ Other (Specify Name): _____

□ None
□ For **E Mail and/or text communication**, I understand that information is not sent in an encrypted manner and there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or obtain a copy of the protected health information to be disclosed as described in this document. (A charge may apply)
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Today's Date
*Description of Personal Representative's Authority (attach necessary documentation).

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