VANTAGE
EYE CENTER

ACKNOWLEDGEMENT

Authorization to Release Protected Health Information (PHI) and Obtain and Use Prescription History

1. With your permission, we may disclose your PHI to the individuals identified below. I authorize Vantage Eye Center to release any personal information relating to my health care

   To: _____ Relationship to Patient: _____

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2. I understand that I have the right to restrict information that may be released, and that this restriction must be in writing. (Please initial below)

   _____ No restrictions

   _____ With restrictions (list): _____

3. I agree that Vantage Eye Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

4. I have received a copy of the Notice of Privacy Practices for Vantage Eye Center, and I acknowledge that I am familiar with and understand the terms and conditions.

Name (printed) _____

_____ _____

Signature Date

Authority for Treatment

IF PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION

No child under the age of 18 (eighteen) may be left unattended!

I hereby authorize the providers at Vantage Eye Center to examine, diagnose and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name: _____ Patient's Date of Birth: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (printed) : _____ Date: _____

Relationship to Patient: _____

If parents are divorced, who is the custodial parent? ☐ Mother ☐ Father ☐ Both (Joint Custody)

Has a legal guardian been appointed? ☐ Yes ☐ No If yes, specify name _____