Lynette Devine, O.D.

10900 Parkside Drive

Knoxville, TN 37934

865-671-2015

Fax 865-671-0122

**Authorization for Disclosure of Medical Information**:

1. I hereby authorize the use or disclosure of my health information. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

 Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Information to be disclosed (check as appropriate)

 \_\_\_\_\_ Most recent eye exam, including glasses and/or contact Rx and health info

 \_\_\_\_\_ Glasses prescription only

 \_\_\_\_\_ Contact lens prescription only

 \_\_\_\_\_ Previous Exams on file (Please specify date range)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_This information is to be disclosed by Dr. Devine **to:**

 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Or**  4.\_\_\_\_This information is to be disclosed to Dr. Devine at Fax 865-671-0122 **by/from**:

 Name/Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise noted, this authorization will expire 45 days from the date signed below.

 6. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions. 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

**Signed**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_