Authorization for Disclosure of Protected Health Information

I hereby authorize Shippee Family Eye Care to use/disclose my individually identifiable health information (which may include information concerning treatment for medical issues and/or testing if applicable).

Full Name (Please print): ______________________________

Date of Birth: ____________________

Mailing Address: ______________________________

Email address (where health information will be sent):____________________

- I understand that my eye care and the payment of my eye care **will not** be affected if I do not sign this form.
- I understand that **I may refuse to sign this authorization.** I also understand that Shippee Family Eye Care shall not refuse to treat me if I refuse to sign this authorization.
- Shippee Family Eye Care is not responsible for a breach of this information if the patient using the portal is using a computer or device that could be compromised.
- I understand that this authorization **may be revoked** in writing at any time requesting that my account be inactivated.

Date: __________

Signature of individual or representative ______________________________

Relationship of representative ______________________________

For office use only:

☐ E-mail address entered into patient demographic. Initials ________ Date __________

☐ Patient activated by: Initials________ Date __________