OWENS OPTOMETRICS – VISION SOURCE SIGNATURE EYE CARE

654 East Main Street, New Holland, PA 17557

PATIENT HIPAA AND AUTHORIZATION FORM

Owens Optometrics Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review of Notice before signing this consent. The Terms of our notice may change and you can request a revised copy by contacting our office. You have the right to revoke this consent by writing.

Patient Name:____Authorized Use and/or Disclosure

The contact person named by you will be given access to all of your information unless otherwise specified by you.

I hereby authorized Owens Optometrics to release to the persons and/or organization listed below the information identified above.

Name:____Relationship______________________

Name:____Relationship______________________

Name:____Relationship______________________

Owens Optometrics has your permission to contact you or leave a message with:

HOME Yes No **MESSAGE SYSTEM** Yes No **WORK** Yes No **FAMILY MEMBER** Yes No

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