Katina Simmons, O.D.
Optometry
8 N Main Street
Jewett City, CT 06351
P: (860) 376 2848 F: (860) 376 4821

PATIENT INFORMATION

Patient name: _____ Date of Birth: _____
Parent/Guardian name: _____Telephone: ( ) -

INFORMATION REQUESTED

I authorize Griswold Eye Care, PLLC to obtain from/release to the information described below:
Name: _____
Address: _____
City/State/Zip: _____, _____ _____
Phone: ( ) - Fax: ( ) -

INFORMATION TO BE DISCLOSED

_____ Complete Health Record _____ Labs _____ Diag. Imaging _____ Immunizations
_____ Other (please describe) _____

THE PURPOSE OF THIS REQUEST IS

_____ Transfer of Care _____ Coordinate Care _____ Relocating _____ Disability
_____ Change of Insurance _____ Legal _____ Dissatisfied with Services
_____ Other (please describe) _____

AUTHORIZATION

I hereby authorize the release of my own or my child's records as described above, including AIDS/HIV (+), sickle cell anemia, behavioral health/psychiatric, drug abuse and/or alcohol related information, if applicable.

I understand that I have the legal right to revoke this authorization at any time by notifying Griswold Eye Care, PLLC., in writing, except to the extent that (a) action has been taken in reliance on the authorization or, (b) this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Unless otherwise revoked, this authorization will expire in 90 days or on the following date, event or condition:

_____

I understand that authorizing information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or have copies made of the information to be used or disclosed. I can contact Joel Zuckerbraun, OD, P.C. if I have questions about disclosure of my health information.

By signing below, I acknowledge that I have read and understand this authorization form.

_____ _____
Signature of Patient or Authorized Representative Today's Date

_____
Print Name of Patient or Authorized Representative