Dr. John Hogg
Optometrist

Meridian Vision

50 E. Carmel Dr. Meridian, ID 83646
Phone: (208)888-5252
Fax: (208)884-4280

I ___________________________, date of birth: ____/____/____, hereby authorize the release of my records from the office of _________________________________to ________________________________.

Phone:________________________ Fax:___________________________

The requested information includes:

- My last eye exam
- Complete record
- Demographics
- Eyeglass prescription
- Contact lens prescription

The release of my protected health information is for the purpose of:

- Ordering eyeglasses or contact lenses
- Reference for new eye exam
- Coordination of treatment

- I understand that I can revoke this authorization at a later date by submitting written or electronic notice of revocation. The exception to this right is if Meridian Vision has already acted in compliance to the authorization.
- I understand that I need not sign this form in order to ensure health care treatment.
- I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- **I have read and understand this form that I am signing voluntarily. I authorize the disclosure of my health information as described in this form.**

___________________________________ Date: ________________________
Print name of patient

____________________________________ Expiration: ____________________
Signature (Patient, parent or guardian)

***If signing as parent or guardian, please specify your relationship to the patient.**

_____________________________ __________________________________
Relationship to patient Print name