Meridian Vision Dr. John Hogg, O.D.

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

I _____(first and last name), ____/____/_____(date of birth), hereby authorize the release of my records from the office of _____ to _____.

Phone:_____ Fax: _____

The requested information is to include:

- ☐ Records from my last eye exam
- ☐ Complete medical and routine record
- ☐ Demographics
- ☐ Eyeglasses Prescription
- ☐ Contact Lens Prescription
- ☐ Other:_____

- ☐ I understand that I can revoke this authorization at a later date by submitting a written or electronic notice of revocation. The exception to this right is if Meridian Vision has already acted in compliance to this authorization.
- ☐ I understand that I do not need to sign this form in order to receive health care treatment.
- ☐ I understand that once the information is disclosed pursuant to this authorization, it may not 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.**

_____ _____

Printed name of patient Date

_____ _____

Signature (Patient, parent, or legal guardian) Expiration

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

_____ _____

Relationship to Patient Printed Name