LUSK
EYE SPECIALISTS

Authorization for Disclosure of Health Information

Patient name: _____

Date of birth:_____ SSN: _____

I. Emergency Contact

Name: _____

Relationship:_____ Phone #: _____

II. My Authorization

Lusk Eye Specialists **may use or disclose a**ll my health information including testing, billing, appointments:

You may disclose this health information to:

1) Name _____

Address: _____City _____State _____Zip_____

Phone #: _____ Secondary Phone #: _____

2) Name _____

Address: _____City _____State _____Zip_____

Phone #: _____ Secondary Phone #: _____

This authorization is good until revoked

III. My Rights

I may revoke this authorization at any time, in writing, sent to Lusk Eye Specialists, at the address provided below. If I do, it will not affect any actions already taken by Lusk Eye Specialists based upon this authorization; uses and disclosures already made cannot be taken back. Lusk Eye Specialists, 451 Ashley Ridge Blvd. Shreveport, LA 71106

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

Patient is unable to sign because of: _____
Age of minor or reason for patient's inability to sign

_____ _____
Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, etc.)