

Authorization for Disclosure of Health Information

2) Name	Patient name:			
Name: Relationship: Phone #: II. My Authorization Lusk Eye Specialists may use or disclose all my health information including testing, billing, appointm You may disclose this health information to: 1) Name	Date of birth:	SSN:		
Relationship:	I. Emergency Contact			
Relationship:	Name:			
Lusk Eye Specialists may use or disclose all my health information including testing, billing, appointm You may disclose this health information to: 1) Name				
You may disclose this health information to: 1) Name	II. My Authorization			
Address:	Lusk Eye Specialists may use o	disclose all my health information in	cluding testing, billing,	appointments:
Address: Secondary Phone #:	You may disclose this health info	ormation to:		
Address: Secondary Phone #:	1) Name			
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 provid it will not affect any actions already taken by Lusk Eye Specialists based upon this authorization; uses an already made cannot be taken back. Lusk Eye Specialists, 451 Ashley Ridge Blvd. Shreveport, LA 71100 Once the office discloses health information, the person or organization that receives it may re-disclose it may no longer protect it. Patient or legally authorized individual signature Date Date				Zip
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 providit will not affect any actions already taken by Lusk Eye Specialists based upon this authorization; uses an already made cannot be taken back. Lusk Eye Specialists, 451 Ashley Ridge Blvd. Shreveport, LA 71100 Once the office discloses health information, the person or organization that receives it may re-disclose it may no longer protect it. Patient or legally authorized individual signature Date Patient is unable to sign because of:	Phone #:	Secondary Phone #:		
Address: Secondary Phone #: Secondary Ph				
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Patient is unable to sign because of:		formation, the person or organization t	that receives it may re-d	lisclose it. Priv
Patient is unable to sign because of:				
Patient is unable to sign because of: Age of minor or reason for patient's inability to sign	Patient or legally authorized individual signatu	Date		
	Patient is unable to sign because o	f: Age of minor or reason for patient's inability to s	ign	
Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, e	Printed name if signed on behalf of the patient	Relationship & Authorit	ty (parent, legal guardian, personal re	presentative, etc.)