Eye Center Northeast
David T. Douglass, O.D., Board Certified
American Board of Optometry
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(207) 990-4388 Fax:(207)947-9241

I,______________________________________DOB:____________________________

Give my permission for Eye Center Northeast, its employees and agents to give information about my health care and health condition to the following person(s):

Family Physician/Specialist:	Family:	Other:
________________	________________	________________
________________	________________	________________

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information. I further understand that I may review my records and refuse authorization to disclose all or some of the health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such. **A Full Notice of our Privacy Practices is available on request.**

This authorization expires **30 MONTHS** from the date hereof and subsequent disclosures by Releasor are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above time frame by notifying Eye Center Northeast of this revocation. Such revocation must be in writing, signed and dated and shall be effective when received, subject to the rights of any such person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits or other insurance coverage or benefits and that I would be responsible for payment for services received.

If I have been diagnosed or treated for any of the following, I understand that Eye Center Northeast needs my specific consent to disclose related information. Please answer the questions by circling "Do" or "Do Not" indicating to the releasor to authorize or not to authorize release/disclosure of said sensitive information . I may cross out any of the following which do not apply. Such information may not be disclosed by the recipient without my specific written consent. I understand that I am entitled to a copy of this authorization form.

I (Do/Do Not) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.

I (Do/Do Not) authorize disclosure of information which refers to treatment and diagnosis of psychiatric illnesses.

I (Do/Do Not) authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARC or Aids

I (Do/Do Not) authorize disclosure of information which refers to treatment or diagnosis to my Pharmacy to do Electronic Prescribing of my Medications

I (Do/Do Not) authorize to be contacted by e-mail for information which refers to treatment or diagnosis and orders for contact lenses, glasses and notification of upcoming appointments. **EMAIL**:____________________

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Patient Signature　　　　　　　　　　　　　　　　　　　　Date

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Authorized Representative/Relationship　　　　　　　　　　　Date