AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (Print): _____

Address: _____

Date of Birth:_____ Social Security Number: _____

I, patient undersigned below, authorize:

Blink Eyecare
Dr. Erin Vogt Stromberg, OD
400 Laskin Rd
Virginia Beach, VA 23451
Fax (757)491-3150 • Telephone (757)428-1675
Email: contactblinkeyecare@gmail.com

to release or obtain my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the following:

☐ All Doctors

☐ Specific Doctors: _____

Exceptions:_____

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records

This authorization shall be in effect for two years from the date of execution unless otherwise revoked sooner.

Authorized Signature_____ Date _____

Relationship to Patient: _____