Authorization to Disclose Personal Health Information

Use this form if you want Drs. Gibson, Gibson, and Moore to release **your personal health information** to someone other than you.

1.) _____ _____ _____
(Name of representative) (DOB) (Telephone number)

2.) _____ _____ _____
(Name of representative) (DOB) (Telephone number)

3.) _____ _____ _____
(Name of representative) (DOB) (Telephone number)

Drs. Gibson, Gibson, and Moore will only disclose the personal health information you want disclosed.

1.) Check only **ONE** circle below to tell Drs. Gibson, Gibson, and Moore the specific personal health information you want disclosed:

- o Limited information (go to question 2)
- o Any information (go to question 3)

2.) Complete **ONLY** if you selected **"Limited information"**. Check all that apply:

- o Information about your eligibility
- o Information about your account (Payables/Receivables)
- o Information about your prescriptions (any eyewear or medications)
- o Other Specific Information (please write below; for example Health Record)

_____

3.) Check **ONLY ONE CIRCLE** below indicating how long Drs. Gibson, Gibson, and Moore can use this authorization to disclose your personal health information:

- o Disclose my personal health information indefinitely
- o Disclose my personal health information for specified period only beginning: _____ and ending: _____

Patient must sign below:

_____ _____ _____
(Patient Name) (DOB) (Date)

_____
(Print Name)