ROOSEVELT VISION CLINIC
Dr. Scott H. Kowallis
Dr. Jon P. Wilson
Dr. Jason N. Kowallis
Dr. Cade J. Kowallis

165 W. 200 N. (71-7)
Roosevelt, UT 84066

T (435)722-2981
F (435)722-3732
rooseveltvisionclinic@yahoo.com

Authorization to Use and Disclose Protected Health Information

• **Authorization to release the protected health information of:**		
Patient Name:		
Date of Birth:	SSN:	Phone: ( )
Current Address:		
City:	State:	ZIP Code:
• **This authorization is to release the protected health information to:**		
Name:		Phone: ( )
Address:		
City:	State:	ZIP Code:
• **This authorization is to release the protected health information from:**		
Facility Name/Provider		
Address		
City:	State:	ZIP Code:
• **The purpose of this disclosure is:**		
Dates of service requested:		

Release the following information:

- ☐ RX for Contact Lenses
- ☐ RX for Glasses
- ☐ Full Medical Records

This authorization will remain in effect until: _____

Unless otherwise noted above, this authorization will remain in effect 180 days from date signed

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to Roosevelt Vision Clinic. If I revoke this Authorization, Roosevelt Vision Clinic may not be able to reverse the use or disclosure of my health information while the Authorization was in effect.

Signature of Patient or Legal Representative:	Date:
If signed by Legal Representative, Authority:	Signature of Witness: