

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

Office of Dr. **Dr. Holcomb & Associates** (Practice Name)

2. Persons/organizations authorized to receive the information: LensCrafters.

3. Specific description of information that may be used/disclosed: My name, address, telephone number, email address and next appointment date(s) and time(s).

4. As part of our recall program, the information will be used/disclosed for the following purposes:

- a) For the purpose of providing LensCrafters coupons and service and product information either from this office or directly from LensCrafters; and
- b) To compare mailing lists with LensCrafters to help avoid duplicate mailings.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

6. The organization authorized to use/discard the information will receive compensation for doing so.

Yes No

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:

- a) action has been taken in reliance on this authorization; or
- b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

9. This authorization expires four years from the date of my signature.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's
authority to act for the patient