

FLORIDA VISION INSTITUTE  
FLORIDA VISION OPTIQUE

1050 Monterey Road • Suite 103 and 104 • Stuart, FL 34994  
1515 North Flagler Drive • Suite 500 • West Palm Beach, FL 33401  
550 Heritage Drive • Suite 105 • Jupiter, FL 33458

Authorization to Use or Disclose Health Information

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

I understand that as part of my healthcare, Florida Vision originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctors, staff, and business associates, of Florida Vision are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies, and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at 1050 Monterey Road, Suite 104, Stuart, FL 34994, Attention: Office Administrator, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed the information would no longer be protected by the federal privacy rule.

This authorization shall expire seven years after my last day of service.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or Authorized Representative      Date

If signed by Patient's Representative, please print name and describe the representative's authority to act for you.

Representative's Name \_\_\_\_\_  
Representative's Authority \_\_\_\_\_

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN  
TO THE PATIENT OR PATIENT'S REPRESENTATIVE

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