Patient Consent Form

Patient Name: _____ **Date of Birth:** _____

I, _____, hereby authorize Dr. Timothy G. Tieu, my optometrist, to
(self, parent or guardian)
release and/or to obtain my medical records from/for the following individual:

☐ **Davis Vision**
169 Express Street
Plainview, New York 11803

☐ **EyeMed Vision Care**
8600 Governor's Hill Drive
Cincinnati, Ohio 45249-3303

☐ **Medicare**
NHIC (EDI Department)
402 Otterson Drive Chico, CA 9592

☐ **Medical Eye Services**
P.O. Box 997100
Long Beach, California 90809

☐ **Superior Vision Services, Inc.**
P.O. Box 967
Rancho Cordova, CA 95741

☐ **Vision Service Plan**
P.O. Box 997100
Sacramento, California 95899-7100

☐ _____

_____

_____

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released for the purpose of health care operations (including, but not limited to, provider review functions, claims payment, and quality assessment). I also understand that I may revoke this consent by written request, at any time, with my optometrist, Dr. Timothy G. Tieu. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for health care operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signature: _____ **Date:** _____
Patient's Signature

Signature: _____ **Date:** _____
Guardian's Signature if under 18

E-mail Form