

**CHARLOTTE OPTOMETRIC EYE CLINIC  
2600 E. 7<sup>TH</sup> STREET, SUITE 104  
CHARLOTTE, NORTH CAROLINA 28204  
(704) 523-1420 PHONE (704) 523-6137 FAX**

**INDIVIDUAL PATIENT'S AUTHORIZATION**

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE:

**1. INDIVIDUAL PATIENT CONFIRMING THE AUTHORIZATION**

I give my authorization to use or disclose my protected health information.  
I give this authorization voluntarily.

**Patient's Name:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_

**Patient's Telephone Number:** \_\_\_\_\_

**Patient's Social Security#:** \_\_\_\_\_

**2. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION**

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

**3. INDIVIDUAL PATIENT'S SIGNATURE**

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS FORM AFTER YOU SIGN IT**