AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use and/or release of my protected health information as descried below. I may refuse to sign this Authorization which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to Dr. James & Enyart Optometrists S.C. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

_____
Name of Patient

_____
Street Address

_____
City, State, Zip Code

_____
Date of Birth

_____
Name of Physician/Facility

_____
Street Address

_____
City, State, Zip Code

To release protected health information to Dr's James and Enyart

185 W. Netherwood St.
Oregon, WI 53538
608-835-3579

700 River Place
Monona, WI 53716
608-223-2020

HEALTH INFORMATION TO BE RELEASED:
_____Ophthalmology/Optometry Records
_____Insurance Eligibility/Benefits
_____Patient Request

Expiration
This authorization will expire on __/__/____(MM,DD,YYYY). If a date is not indicated this will expire one (1) year form the date of the signature below.

Signature_____Date_____