Levenson eye associates

LevensonEyeAssociates.com | 904-366-3781

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print): _____ Date of Birth: _____

This form does not apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies, and workers compensation agencies. We cannot release ANY of your medical information to any person or organization (including family members, spouse, etc.) unless you list their names below.

I give permission to the **LEVENSON EYE ASSOCIATES** to discuss the following medical and billing information about me (check all that apply):

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnoses, medications, and treatment plan)
- ☐ Laboratory/Test Results
- ☐ Financial Details/Payment Information
- ☐ All the Above
- ☐ Other: _____

LEVENSON EYE ASSOCIATES has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to the **LEVENSON EYE ASSOCIATES**. I will contact **LEVENSON EYE ASSOCIATES** Privacy Contact in writing to terminate the authorization.

This authorization expires:

- ☐ No expiration date
- ☐ Date specified ____ / ____ / ____ unless revoked or terminated in writing by you or your patient personal representative.
- ☐ I decline permission to discuss medical information.

Patient / Parent or Guardian Signature _____ Date _____

Staff Member _____ Date _____

Riverside Park Place
751 Oak Street
Suite 200
Jacksonville, FL 32204

Mandarin
3020 Hartley Road
Suite 190
Jacksonville, FL 32257

Orange Park
905 Park Avenue
Suite 104
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Ponte Vedra Beach
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Suite 102
Ponte Vedra Beach, FL 32082

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2535 Riverside Avenue
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