Danbury Eye Physicians & Surgeons, P.C.

69 Sand Pit Road Danbury, CT 06810 203-791-2020
120 Park Lane, B203, New Milford, CT 06776 860-946-6000
166 Waterbury Road, Suite 201, Prospect, CT 06712 203-758-5733
215 Main Street, Westport, CT 06880 203-221-8600

OPTIONAL FORM

DATE: _____

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

PATIENTS EMAIL: _____ (For Patient Portal)

I give permission for: _____ _____ _____
Name Relationship to Patient Phone #

_____ _____ _____
Name Relationship to Patient Phone #

To have access to:

☐ Speak to the Doctor regarding my medical condition

☐ My Billing Information

☐ My Medical Records

By signing this form, you authorize Danbury Eye Physicians & Surgeons to use and disclose protected health information about you for the reasons mentioned above. If applicable, this may include information about HIV, AIDS, substance abuse, alcohol abuse, drug abuse, mental health, sexually transmitted diseases, or any sensitive information, etc. **This release is valid unless specified or revoked**. You have the right to revoke this authorization at any time in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Office of the practice.

This authorization is signed by : _____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

REV:4/2017