Authorization to Share Protected Health Information with an Individual(s)

At my request, I, _____,

□ Authorize Lifetime Vision Care to disclose any or all of my protected health information maintained by Lifetime Vision Care to the below listed individual(s):

_____

_____

_____

□ Decline to add anyone at this time, please do not disclose any of my protected health information

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to Lifetime Vision Care.

X_____ _____

Signature of patient Date