

**Authorization to Disclose Protected Health Information (PHI) to Another Individual**

**Burke Optometry**  
441 S Ham Lane Ste B  
Lodi, Ca 95242

**Patient Information**

- **Full Name:** \_\_\_\_\_
  - **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  - **Phone Number:** \_\_\_\_\_
- 

**I authorize Burke Optometry to release my health information to:**

- **Name of Authorized Individual:** \_\_\_\_\_
  - **Relationship to Patient:** \_\_\_\_\_
  - **Phone Number:** \_\_\_\_\_
- 

**Information to Be Disclosed (Check all that apply):**

- All medical records
  - Billing information
  - Treatment and progress notes
  - Imaging reports
  - Other: \_\_\_\_\_
- 

**Purpose of Disclosure:**

- Personal use
  - Continuity of care
  - Insurance or legal purposes
  - Other: \_\_\_\_\_
-

**Method of Disclosure (Check all that apply):**

- Verbal communication
  - Printed records
  - Electronic communication (email, patient portal, etc.)
- 

**Acknowledgment and Signature**

I understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by submitting a written request to Burke Optometry.
- Revocation will not affect disclosures made prior to receipt of the revocation.
- The information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.
- This authorization expires one year from the date of signature unless I specify otherwise.

**Expiration Date (optional):** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Signature of Patient or Legal Representative:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**If signed by a legal representative, describe your authority:** \_\_\_\_\_