

Children's Eye Care of Los Gatos, Inc

250 ALMENDRA AVE, LOS GATOS, CA 95030 OFFICE (408) 399-9009 FAX (408) 399-9073

Authorization for Disclosure of Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Children's Eye Care of Los Gatos, Inc. is authorized to disclose this patient's complete medical records as described below.

I authorize the use or disclosure of the above named individual's health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome or human immunodeficiency virus. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time and done in writing to the above office. Unless otherwise revoked, this authorization will expire in **one year** unless a date is specified. Authorization expires on _____

This information may be disclosed to:

NAME: _____
ADDRESS: _____
Fax: _____

Signature of patient/ parent/ or legal guardian _____
Name of Parent or Legal guardian: _____
Date: _____