**VERDIER EYE CENTER, PLC**

**1000 E PARIS AVE SE SUITE 130**

**GRAND RAPIDS, MI 49546**

**616-949-2001**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the following person (s) access to all of my medical information. The person(s) listed below are allowed to discuss my treatment, diagnosis, and continuing plan of care with my doctor or staff member (s) of Verdier Eye Center, PLC.

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| --- | --- | --- | --- | --- |
| **Name** | **Relationship** | **Phone Number** | **Patient Portal Access**  **Y or N** | **Email Address** |
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I understand that I may revoke this authorization in its entirety at anytime or I may remove the name of a person at anytime by contact Verdier Eye Center at 616-949-2001. Be aware that Verdier Eye Center, PLC is unable to take back any disclosures we have already made with your permission. I understand in case of an emergency that my doctor or staff member may discuss my condition with my caregiver or relative. This authorization will remain in effect until terminated by you, your personal representative, or another individual of legal entity authorized to do so by court order or law.

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Patient Signature Date