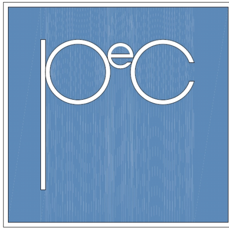

P R E C I S I O N E Y E C A R E

D R. V I C T O R I A Y U , O . D .
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

To insure compliancy with federal regulations, regarding the privacy act known as HIPPA (Health Information Portability & Accountability Act), we will need the following information to identify you properly and your written authorization ro release and/or request your optometric records to be sent to/from another provider.

Patient's Name: ______________________________ Date of Birth: _____/_____/___________

Previous Name: ______________________________ SSN: _________-_______-_____________

I request and authorize ____ _____to release health information of the patient named above to:

Name: PRECISION EYE CARE, DR. VICTORIA YU, OD
Address: 300 E DIMOND BLVD. STE 14
City: ANCHORAGE State: AK Zip: 99515

This request and authorization applies to: ____

☐ Complete Copy of Optometric Records including OCT & VF Test Results

☐ Eye glass prescription ☐ Last Exam Information

☐ Contact lens prescription ☐ Other __________________

Information listed above will be disclosed for the following purpose:

☐ Continued Care ☐ Terminating Care

☐ Seeking Second Opinion ☐ Personal Use

Patient Signature: ____________________________ Date Signed: ________________________