



Authorization to Release Information Verbally

Patient Name: _____ DOB: _____

Account #: _____ SSN: _____

Information to be released/discussed:

- | | |
|--|---|
| <input type="checkbox"/> Medical Information | <input type="checkbox"/> Specific Date(s) of Service: _____ |
| <input type="checkbox"/> Billing Information | <input type="checkbox"/> All Dates of Service |
| <input type="checkbox"/> Diagnosis/Treatment Plans | |
| <input type="checkbox"/> Prescriptions/Refills | |
| <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Can make changes |
| <input type="checkbox"/> All Information/Records | <input type="checkbox"/> Cannot make changes |

To be released to whom:

Name: _____

Relation to Patient: _____

In accordance with HIPAA LAW, I, the above-listed patient, hereby authorize the staff and physicians at Katherine E Johnson MD PC, aka Mountain View Eye Center and Mountain View Optical Shoppe, to release the information in the form of verbal discussion with the individual named for the specified dates of service or until this authorization expires or is revoked. I understand that in order for the above-named individual to acquire any written documents regarding my health or my account, I will need to fill out a separate release of information form for specified dates of service. I acknowledge by my signature that I understand that although I am not required to release my information, I am giving my consent to do so. This authorization expires in three years or on _____, whichever is sooner. I understand that I may revoke this authorization in writing at any time before it expires, except for that information which has already been released with consent and prior to my revocation.

Patient Signature

Date