

INDIVIDUAL PATIENT'S AUTHORIZATION

I give my authorization to Dr. Bobby L. Chan and associates to use or disclose my protected health information as described below. I give this authorization voluntarily. This authorization is in effect until it is revoked in writing.

I authorize Dr. Bobby L. Chan and associates to release and furnish on a confidential and a strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by the third parties for the services rendered by Dr. Bobby L. Chan and associates, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies or other governmental or third-party payers, or any organization contracting with any of the above entities to perform such functions. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I also give my authorization to have a copy of my medical records delivered to any other physician that is directly or indirectly responsible for my care or payment thereof.

I also give my authorization for _____ (e.g. spouse) to talk to the office staff about my financial data and all medical information.

I consent to receive related patient communications regarding health care services such as mailings of exam reminder/recall cards or explanations of services/products provided by the office.

I also give my authorization for _____ to receive my glasses or contact lens prescriptions.

I wish to be contacted in the following manner (check all that applies):

- Home Telephone
- Work Telephone
- Cell Phone
- Permission to leave message with detailed information
- Leave message with call back numbers only
- Permission to mail to my home address
- Permission to fax to this number: _____

Signature of Patient or Guardian Date

I have read and comprehend The Notice of Privacy Practices:

Patient or Guardian Signature: _____ Date: _____
The Notice of Privacy Practice will remain in effect forever.