I understand that I have the right to revoke this authorization, in writing, at any time, except:

(1) where uses or disclosures have already been made based upon my original permission, or

(2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

To revoke this authorization, I must do so in writing and send it to:

THE CHILDREN'S EYE CENTER
Nieca D. Caltrider, MD, Dave H. Lee, MD & Ellen R. Miller, MD
4110 Briargate Parkway #440
Colorado Springs, CO 80920

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by recipient and no longer protected by the federal Privacy Standards.

_________(Initials of patient, parent or legal guardian) I understand that The Children's Eye Center may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

_______________________________________ ______________

Signature of Patient, Parent or Legal Guardian** **Date**

_______________________________________ ______________

Print Name of Patient **Date of Birth**

_______________________________________ ______________

Print Name of Parent or Legal Guardian **Date of Birth**

* * If an authorization is signed by an individual's personal representative, the representative's authority is based on: ________________________

________________________________ (e.g., state law, court order, etc.)