THE CHILDREN'S EYE CENTER HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

4110 Briargate Parkway #440
Colorado Springs, CO 80920
Telephone: 719-574-1654
Fax: 719-574-5381

By signing this form, I, _____, authorize the use and disclosure of my health information as described below:

1. Description of Information: _____

_____

2. Name the people and/or organizations that you are authorizing to use and/or disclose the protected health information described above.
REQUESTING INFORMATION FROM:

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

3. Name the people and/or organizations that you are authorizing to receive and use your protected health information:
(e.g., doctor, patient, parent, legal guardian, attorney, school, other...)

_____

_____

4. Date or event when authorization expires: _____

5. Description of each purpose of the requested use or disclosure:

_____

_____