BAUSCH + LOMB

Contact Lens Parameter Consent and Release Form

By signing this form I, _____ authorize the release of protected health information described below to _____ (Provider Name) who is now associated with my eyecare.

I authorize the release of the design and brand of contact lens you have on record that was fit by a previous eye care provider as well as any other healthcare information you have on file related to my contact lens prescription.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

This authorization shall be in full force and effect until _____ (insert date) at which time this authorization shall expire.

I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name _____

Address _____

City _____

State _____

Zip/ Postal Code _____

Patient Signature _____

Date _____

SUBMIT

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