GREAT LAKES EYE Institute
Eye Clinic and Surgery Center

Farhad K. Shokoohi M.D., F.A.C.S.
Retina and Vitreous Diseases and Surgery

John M. O'Grady, M.D.
Cataract, Glaucoma, and Refractive Surgery

Majed J. Sahouri, M.D.
Comprehensive Ophthalmology

Kamran K. Shokoohi, M.D., Ph.D.
Retina/Vitreous Diseases and Surgery
Comprehensive Ophthalmology

Daniel J. Lin, M.D.
Neuro-Ophthalmic
Plastic Reconstructive Surgery

Richard A. Kaiserman, M.D.
Cataract Surgery
Comprehensive Ophthalmology

Brian D. Dudenhoefer, M.D.
Cataract Surgery
Comprehensive Ophthalmology

Moonyoung S. Chung, M.D.
Cornea
Comprehensive Ophthalmology

Joshua S. Grant, M.D.
Medical Retina and Vitreous

Scott M. Vandenbelt, M.D.
Cataract and Refractive Surgery
Comprehensive Ophthalmology

Nicholas D. Shokoohi, M.D.
Cataract Surgery
Comprehensive Ophthalmology

Patrick J. Bell, O.D.
Comprehensive Optometry

D. Bart Darnell, O.D.
Comprehensive Optometry

Kristine M. Weaver, O.D.
Comprehensive Optometry
Low Vision

GREAT LAKES EYE INSTITUTE

AUTHORIZATION FORM TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

PLEASE READ THIS DOCUMENT CAREFULLY

Name of Patient: ________________________________ **DOB** ______________

This is an authorization form that will permit Great Lakes Eye Institute ("Covered Entity") to use or disclose some of your protected health information. Covered Entity will not condition treatment on whether you sign this authorization. You have the right to revoke this authorization at any time by sending a *written* revocation to:

Privacy Official: Farhad Shokoohi, MD, GLEI, 2393 Schust Road, Saginaw, MI 48603

Your revocation will not apply, however, to uses and disclosures Covered Entity has already made in reliance on your authorization.

I authorize Covered Entity to use and disclose the following health information about me:

____
____
____

To the following entity or persons:

(Name and address of entity or persons to receive records): ________________
____
____
____

Purpose of disclosure:

____

This authorization allows GLEI to release **all** records as requested **including** records on mental health, substance abuse, HIV, and sexually transmitted disease, unless this authorization specifically restricts release of such records.

Restrictions (if any): ____

This authorization is valid until ______________________________**, 20**___.

Please provide the following information if you are a personal representative of a patient of Covered Entity:

1. Your printed name: ______________________________________
2. Description of personal representative's authority: ____________________
3. Where applicable, Guardianship and or Power of Attorney documentation must be provided to Covered Entity before release of PHI can be granted.

Please Read Carefully and Sign

I understand that Covered Entity will use or disclose my health information as described above until this authorization expires. I understand that I will receive a copy of this signed authorization for my records. I also understand that any health information released pursuant to this authorization might be re-disclosed by the recipient, and that any such re-disclosure may not be protected by law.

______________________________________ ______________
Patient's Signature (or Guardian's Signature) Date

2393 Schust Rd. Saginaw, MI 48603	407 W. Wackerly Midland, MI 48640	623 W. Warwick Dr., Ste. 1 Alma, MI 48801	4624 Hill St. Cass City, MI 48726	406 W. Genesee Frankenmuth, MI 48734	1671 E. US Hwy. 23 East Tawas, MI 48730	800 Woodside Ave. Bay City, MI 48708
(989) 793-2820 Fax: (989) 793-9132	(989) 631-1345 Fax: (989) 631-5129	(989) 463-1126 Fax: (989) 463-6013	(989) 872-3800 Fax: (989) 872-4525	(989) 652-2020 Fax: (989) 652-9444	(989) 362-4401 Fax: (989) 362-8141	(989) 892-6616 Fax: (989) 892-6651

www.greatlakeseyeinst.com