INTERMOUNTAIN
EYE CENTER

Brent S. Betts, M.D.
Kathryn M. Fethke, M.D.
Jon R. Fishburn, M.D. FACS
Molly J. Mannschreck, M.D.
Adam C. Reynolds, M.D.
James P. Tweeten, M.D.
Lee J. Carter, O.D.
Vanessa Ewing, O.D. F.A.A.O
Brandon C. Hicks, O.D.
Luke K. Hopstad, O.D.
Deric C. Simmons. O.D.

AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) took effect on April 14, 2003.

In order to comply with this regulation, we need an authorization from you to release any health care information to family members, friends, etc.

Below, please list all the people you would like to authorize on your behalf:

NAME PHONE NUMBER

I, the undersigned patient, give Intermountain Eye Center permission to share any of my information with the named people above. I authorize the release of information including the diagnosis, records; examination and claims information rendered to me and the persons named above.

*The release of information will remain in effect until terminated by me in writing.

Patient Name: _____

Patient DOB: _____

Patient Signature: _____

Date: _____