Robert A. Yohai, M.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ____

I hereby authorize Robert A. Yohai, M.D. to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that this authorization is voluntary.

Any and all of the following Health Information may be disclosed by Advanced Eyecare:

Medical Records
Claims/Billing Information
Other _____________________________________

This Health Information will be used only for the purpose of allowing Advanced Eyecare and its Business Associates to pursue and receive reimbursement of claims from any and all responsible third parties, as allowed in the members' health plan or insurance policy. Advanced Eyecare will not receive any financial or "in-kind" compensation as payment for disclosing the Health Information described above.

I understand that my health care will not be affected if I do not sign this form except that I agree to pay in full on the day services are rendered.

I also understand that I may revoke this authorization at any time by notifying Advanced Eyecare in writing. I understand that my revocation of this authorization will not affect any actions taken by Advanced Eyecare in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: ____ Dated: ________________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of deceased patient.