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DOCTORS

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT INFORMATION

LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ APT / SUITE _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____

I authorize the professional office of my optometrist named on the left to release health information identifying me, including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services, under the following terms and conditions:

Detailed description of the information to be released:

❍ copy of contact lens prescription
❍ copy of glasses prescription
❍ copy of last exam
❍ copy of entire record (I agree to pay a $1 per page charge)
❍ other: _____

Release the information to: _____

The purpose(s) for the release:
(if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose)

❍ at the request of the individual
❍ other: _____

Expiration date or event relating to the individual or purpose for the release: _____

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the left of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

PATIENT'S SIGNATURE _____ DATE _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

RELATIONSHIP TO PATIENT _____

SOURCE OF AUTHORITY _____

PRINT NAME _____

SIGNATURE _____ DATE _____