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DOCTORS

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT INFORMATION

Form fields for 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 top 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