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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

(This Form is used to send our records of a patient to another office)

Patient name _____

Patient address _____

Patient phone number _____

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

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) or recipients]:
3. The purpose(s) for the release (if the authorization is initialized by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

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 not 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 FOR MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:_____ Patient Signature _____

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 _____ Print Name _____

Source of Authority _____

RECORDS RELEASE FORM

This form is used to send our records of a patient to another office:

Patient:	
Send Records To:	
Today's Date:	
Expiration Date:	