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Office contact persons: Linda Borrell/Tracey Needham, O.D.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMAITON

Patient Name_____

Patient Address_____

Patient Phone Number_____

I authorize the 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 abuse treatment and information about mental health services) under the following terms and conditions:

1._____
(Detailed description of the information to be released)

2.To:_____From:_____
_____   _____
_____   _____
(The information may be released To:/From:)

3._____
(The purpose for the release)

4._____
(Expiration date or event relating to the individual or purpose of 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 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 it's 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 Signature_____Date_____

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

Relationship to Patient_____Print Name_____

Source of Authority_____