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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient Address:_____

Patient Phone:_____

Doctors Office:_____

Address:_____

_____

Phone: _____

Fax: _____

I authorize the office named above to release health information identifying me, including but not limited to eyeglass prescriptions, contact lens prescriptions, pupillary distances, exam history and notations.

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 may change this possibility. Our office is HIPAA compliant and protects your information.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF THE HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient 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: _____ Print Name: _____

Source of authority: _____