AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Phone Number _____

I authorize the release of health information identifying me *(including, if applicable, information about substance abuse, mental health conditions, HIV infection and AIDS)* under the following conditions:

☐ I authorize the office listed below to release all records and any pertinent information to **Family EyeCare Center**.

Office Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

☐ I authorize **Family EyeCare Center** to release all records and any pertinent information to the office listed below.

Office Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign it. If you do sign, you may revoke it at any time by contacting our Privacy Official, noted in the the Notice of Privacy Practices, via fax, email or letter.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature _____ Date _____

Representative _____ Relationship to Patient _____

If you are signing as a personal representative of the patient, please indicate your relationship.

Records_Release
4/27/2017

FAMILY EYECARE CENTER
DOCTORS of OPTOMETRY
COMPASSION | INTEGRITY | INNOVATION

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