Vision Partners LLC

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name:_____ DOB:_____

Patient Account number:_____ SS#:_____

Patient address _____

Patient phone number _____

I authorize _____ 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: **AREAS 1-4 MUST BE COMPLETED, CHECK OFF BOXES!**

1. **Detailed description of the information to be released:** __Exams __Operative Reports ___Optical Orders, Prescriptions __Diagnostic/lab Test ___Billing Information ___Demographics __Photos ___Medical History ___Other_____

2. **To whom may the information be released [name(s) or class(es) of recipients]:** ***CHECK ONE***, __Vision Partners __Premier Medical ____ Other_____

3. **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, if desired by the individual):** ____At the request of the individual _____Other_____

4. **Expiration date or event relating to the individual or purpose for the release:** ___One Year __six months ___Three months ___after this occurrence other_____

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 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.

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 _____(Court appointment, legal guardian, Power of Attorney, etc)