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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

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, substance abuse treatment, and 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) of recipients):**

   _____

3. **Purpose(s) for the release** (if this authorization is initiated by the patient, "at the request of the individual" is acceptable):

   _____

4. **Expiration date or event related to the individual or the purpose for the release:**

   _____

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 this form.

If you do sign this authorization, you may revoke it at any time. The only exception is if we have already taken action in reliance on this authorization. To revoke this authorization, you must send us a written or electronic statement requesting its revocation. Please send this to the office contact listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient may not be legally obligated to protect its confidentiality. In many cases, the recipient may re-disclose the information freely. However, certain federal and state laws may limit this possibility.

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

Patient Signature: _____ **Date:** _____

If you are signing as a personal representative of the patient, please complete the following:

Relationship to Patient: _____ | **Printed Name:** _____
Source of Authority: _____