PersonalEYES VISION CARE

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Contact Person: Nancy Spears

Records Release / Request Authorization Form

Authorization for Release/Request of Identifying Health Information

Patient Name_____ Date of Birth_____

Patient Address: _____

I authorize the professional office named above to:

_____ RELEASE Information TO *OR* _____ OBTAIN Information FROM

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____

Information Requested: _____All Records

_____Other:_____

This authorization shall expire on _____ (date) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

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. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except 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 above.

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

We will not receive a financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____ _____

Signature Date

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

_____ _____

Signature Printed Name

Source of Authority: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____