Dr. Muneer N. Hanna & Associates, PA
Board Certified Doctors of Optometry
Contact Person: Lana Hanna

NAS Jax Exchange
Bldg. 987, Box 104
Jacksonville, FL 32212

Hanna Eye Care
1704 Southside Blvd.
Jacksonville, FL 32216

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____ Chart # _____

Patient Phone Number _____

Patient Address _____

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, under the following terms and conditions:

1. Information to be released: Name, address, phone numbers, identification numbers, dates of exams, insurance information, photos, prescriptions, date of birth, and diagnostic coding.
2. To whom may the information be released: only to other health care providers or health insurance claims personnel.
3. The purpose for the release: to carry out treatment, payment, or healthcare operations of the practice.
4. Expiration date: none, unless otherwise specified by the above named patient.

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 note telling us that your authorization is revoked. Send this note to the office contact person 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.

I HAVE ALSO REVIEWED DR. MUNEER N. HANNA & ASSOCIATES' NOTICE OF PRIVACY PRACTICES WHICH IS POSTED IN THE WAITING ROOMS OF ALL THREE OFFICES. THIS NOTICE OF PRIVACY PRACTICES DESCRIBES MY RIGHTS AND THE DUTIES OF THIS OFFICE WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. ANY FUTURE REVISIONS TO THIS NOTICE OF PRIVACY PRACTICES WILL BE AVAILABLE TO ME AT MY REQUEST.

Dated _____ Print Name _____

Relationship to patient _____ Patient signature _____

Source of authority_____

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.