Dr. Robert C. Janot - Vision Source
(337) 625-2020, fax: (337) 625-2027 info@janotvision.com
Public Information & Privacy Officer: Dr. Robert C. Janot

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Date of Birth_____Patient phone number _____

Patient address _____

I authorize _____(clinic or Doctor) to release health information identifying me under the following terms and conditions. I understand that this authorization is voluntary.

1. Detailed description of the information to be released:

   - Copies of complete Eye / Medical Records including special tests, special reports, & any outside Dr. communications
   - Retinal photos, including Optomap LASER scans, if available
   - Contact lens and / or glasses prescriptions

2. This information is to be released solely to: Dr. Robert C Janot - Vision Source, 3817 Maplewood Drive, Sulphur, LA. 70663. Fax: 337-625-2027

3. The purpose(s) for the release is: At the request of the individual & to provide continuity of care.

4. This authorization will expire 1 year from the date below.

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 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.

If this form is being used for marketing or advertisement purposes, Dr. Robert C. Janot - Vision Source may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

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 _____ Signature_____**OR**

Printed name of patient's representative:_____

Relationship to Patient:_____