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Authorization to Release/Disclose Patient Health Information

By signing this form, I authorize the disclosure or receipt of my protected health information.

Patient information:

Last Name:_____ First Name:_____

Date of Birth:_____ Phone: _____

Address:_____

City:_____ State:_____ Zip:_____

Health information to be released:

- ☐ Complete Exam Information
- ☐ Glasses Prescription
- ☐ Glasses Ordered
- ☐ Special Testing Results
- ☐ Contact Lens Prescription
- ☐ Contact Lenses Ordered
- ☐ Other

Information may be disclosed to the following individual/organization:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax: _____

I understand my records may contain information related to any ocular conditions or systemic diseases which I currently have or had in the past. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that according to the HIPAA Privacy Rule, this office may take **up to 30 days** to provide written records.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to Patient:_____