YOUNG
VISION CARE

You WILL see the difference!

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information	I hereby authorize and request the disclosure of information from the health records of: Patient Name: _____ Phone #: _____ Address/City/State/Zip: _____ Date of Birth: _____ SSN: _____
Purpose	☐Continuation of Care ☐Insurance ☐Legal ☐Worker's Compensation ☐Personal/Other
Release of Records TO Young Vision Care	☐Release medical records to Young Vision Care From: Name: _____ Fax #: _____ Address/City/State/Zip: _____ For the time period of: Last 5 years of visual fields / Last 3 years of exams _____ to Present
Release of Records FROM Young Vision Care	☐Release medical records from Young Vision Care To: Name: _____ Fax #: _____ Address/City/State/Zip: _____ ☐Mail or ☐Fax records directly to the person or organization specified above. ☐Call Me for pick up when records are ready For the time period of: _____ to _____
Authorization	I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. I understand that when a health care provider uses or discloses my health information as I have instructed in this authorization, they do not have the ability to monitor whether my health information may be further used or disclosed by such parties. In such a situation, my disclosed health information may no longer be protected by federal and state privacy laws. This authorization will automatically expire one year from the date of this request, or on the following requested date: _____
Signatures	**My Signature is required to validate this authorization/request** _____ _____ **Signature of Patient/Guardian/Authorized Representative** **Date** _____ _____ **Witness** **Date**

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