FRONT RANGE EYE HEALTH CENTER, P.C.
Visual, Medical and Surgical Eye Care

Authorization for Release of Identifying Health Information

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DOCTORS
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SPECIALIZING IN
Medical Eye Care
Eye Examinations
Surgical Eye Care
Contact Lens Care
Optical Services

Patient Name: _____ DOB: _____
Address: _____ Phone: _____

I authorize the professional office of my doctor, name circled to the left, to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
   ☐ All (no restriction)
   ☐ Describe Information: _____

   To whom may the information be released [name(s) or class(es) of recipients]:
   Name: _____
   Address: _____
   Phone: _____ Fax: _____

2. The purpose(s) for the release (it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
   ☐ At the request of the patient
   ☐ Other (describe): _____

3. Expiration date or event relating to the individual or purpose for the release: _____

It is completely your decision whether or not to sign this authorization form. 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.

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 you are authorizing us to use your health information for marketing activities, please be advised that we 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.

Patient Signature: _____ Date: _____

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:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

CINDY J. BEEKS O.D., HIPAA COMPLIANCE OFFICER