ACCENTVISION SPECIALISTS

DR. DWIGHT THIBODEAUX ▼ DR. PAUL TACHAU ▼ DR. SEAN HAMASHIGE

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient Name_____ DOB_____

Person(s)/organization(s) **providing** information: ☐Accent Vision Specialists

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Person(s)/Organization(s) **using or receiving** information:

1._____ ☐Mail ☐Fax ☐Pick up

2._____ ☐Mail ☐Fax ☐Pick up

Description of **each** purpose of authorized use or disclosure:

1._____

2._____

Conditions and Notifications:

This authorization for release of information expires 12 months from the date of patient's signature. This authorization may be revoked at any time by notifying the Privacy Officer at Accent Vision Specialists in writing to 1645 Galisteo Street, Santa Fe, NM 87505. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of this form and health information to be used or disclosed, consistent with federal law. **This request for access to records can take up to 30 days to fulfill but Accent Vision Specialists strives to process all requests within 1 week**.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that my health care will not be affected if I do not sign this form. If I refuse, the records will not be disclosed. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

_____ _____

Signature of patient or patient's representative Date

Printed name of patient's rep._____ Relationship to patient_____

_____ _____

Witness Signature Date

Optometric Physicians Providing Ophthalmic Medical and Optical Services

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