

# Vision Partners LLC

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## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Account number: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I authorize \_\_\_\_\_ 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: **AREAS 1-4 MUST BE COMPLETED, CHECK OFF BOXES!**

1. **Detailed description of the information to be released:**  Exams  Operative Reports  Optical Orders, Prescriptions  Diagnostic/lab Test  Billing Information  Demographics  Photos  Medical History  Other \_\_\_\_\_

2. **To whom may the information be released [name(s) or class(es) of recipients]:** **CHECK ONE,**  Vision Partners  Premier Medical  Other \_\_\_\_\_

3. **The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):**  At the request of the individual  Other \_\_\_\_\_

4. **Expiration date or event relating to the individual or purpose for the release:**  One Year  six months  Three months  after this occurrence  other \_\_\_\_\_

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 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.

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 \_\_\_\_\_ Patient signature \_\_\_\_\_

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 \_\_\_\_\_ ( Court appointment, legal guardian, Power of Attorney, etc)

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