Vision Partners LLC

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____ Acct #_____

Patient Phone #_____ Social Security Number:_____

Patient Mailing Address:_____

City _____ State:_____ Zip:_____

REQUEST RECORDS TO BE OBTAINED FROM: _____
(Practice OR Doctor First and Last Name)

ADDRESS:_____ CITY_____ ST_____ ZIP_____

PHONE #_____ FAX #:_____

I authorize_____ (Dr First, Last Name) 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 conditions:

THE FOLLOWING QUESTIONS MUST BE ANSWERED TO COMPLETE REQUEST-PLEASE CHECK BOXES!

1. **Detailed description of the information to be released**: _____ Exams ____ Operative Reports ___Optical Orders ___Prescriptions ___Diagnostic/Lab Tests ___Billing Information ___Demographics ___Photos ___Medical History ___ Other Information:_____

2. **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.
Please state purpose _____At the request of the individual Other:_____

3. Expiration date or event relating to the individual or purpose for the release: ____One Year ____Six Months ____Three Months ____After this occurrence ____Other

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RECORDS TO BE SENT TO: _____
First Name, Last Name of the Person, Doctor or Practice Name

ADDRESS:_____ CITY:_____ST_____ ZIP_____

FAX #:_____ PHONE #:_____

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 notice 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, Parent)