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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

INFORMATION IS BEING REQUESTED FROM:_____

INFORMATION IS BEING RELEASED TO:_____

SPECIFIC DATA REQUESTED:

_____ **Original and latest keratometry readings**
_____ **Original and latest refraction**
_____ **Current contact lens specifications**
_____ **Visual Fields**
_____ **Intraocular Pressures**
_____ **Optic Nerve Assessment/Photos**
_____ **All Records**
_____ **Other:**_____
_____

PURPOSE OF INFORMATION TO BE RELEASED:

We will not receive a financial benefit from disclosing this health information about you. 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 this office. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect your confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

DISCLAIMER REGARDING THE TRANSMISSION OF RECORDS VIA E-MAIL:

E-mail sent from this office is unencrypted. If you wish to have your personal health information sent via e-mail, please be aware that this may not be the most secure method of transmission. By providing an e-mail above, you are giving consent to send your personal health information in an unencrypted e-mail.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE PROFESSIONAL OFFICES NAMED HEREIN TO RELEASE HEALTH INFORMATION IDENTIFYING ME (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental services) UNDER THE ABOVE TERMS AND CONDITIONS.

PATIENT NAME:_____ **DOB:**_____

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:_____