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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient name:_____

Patient number:_____

Patient address:_____

Patient phone number:_____

I authorize the professional office of my optometrist named above 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:
    a. All (no restriction)
    b. Describe Information:
2. To whom may the information be released [name(s) or class(es) of recipients]:
    a. Name:_____
    b. Address:_____

   c. Phone: (___)_____
   d. Fax: (___)_____

3. 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):
   a. At the request of the patient
   b. Other (describe):
4. 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.

Member
American Optometric Association

_____	_____	_____
Signature	Date	Patient Name

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Source of Authority