

Walkersville Eyecare
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Authorization for Release of Identifying Health Information

Date: _____ Patient's Full Name: _____

Date of Birth: _____

I authorize the professional office of my optometrist named above to release health information identifying me under the following terms and conditions:

1. To whom may your private medical information be released? Please name the people and/or the organizations (or the kinds of people and/or organizations) that you have authorized to receive your private medical information:

2. Is there a particular person(s) who should not get this information?

3. What information can be released?
 - Contact lens prescription
 - Eyeglass prescription
 - Results of diagnostic tests
 - Prescribed medication
 - Other _____
4. Please list an expiration date for the release of this information:
 - No expiration date for this release.
 - I authorize this release to end on the following date: _____

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 form, 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 contact person 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.

Date: _____ Patient or Guardian's Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient: _____ Print Your Name: _____