AUTHORIZATION FOR RECORDS RELEASE

Center Vision
& CONTACT LENS CLINIC

Patient name _____

Date of Birth _____

Last 4-Digits of Social Security Number_____

Patient phone number _____

I hereby authorize Center Vision & Contact Lens Clinic to release my health information under the following terms and conditions:

1. Description of the information to be released:

_____ All information contained in the patient's file, including copies of medical records and copies of records received from any other person or firm with respect to the exam, treatment and care.

_____ Other: _____

2. To whom may the information be released to:

Name:_____

Address: _____

City/State/Zip:_____

Phone/Fax Number: _____

3. Purpose of the release: _____

4. Date of request: _____

In April 2003, a new law took affect that created a nationwide standard for protecting personal health information. That law is commonly known as HIPAA. The HIPAA privacy regulations apply to everyone with access to personal medical information. At Center Vision & Contact Lens Clinic, we are commited to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential.

I understand that once Center Vision & Contact Lens Clinic discloses health information as provided in the authorization request, the recipient may re-disclose the information and may no longer be protected under HIPAA.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written notification.

Signature:_____ Date:_____
(Patient / Guardian / Legal Representative)

Relationship to patient:_____

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