Hussey Eyecare

VISION SOURCE

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INORMATION

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

I authorize Hussey Eyecare to release health information identifying me (including, if applicable, information about substance abuse, metal health conditions, and HIV infection or Aids) under the following conditions:

This form is an agreement to the release of all medical information pertaining to the above listed patient from all providers at the below location(s):

_____

_____

_____

Hussey Eyecare stands no monetary gain at the acquisition or release of patient records. This form will expire five years from the date of signature. It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization, you may revoke it at any time by contacting in writing, fax, or email the Privacy Official noted in the Notice of Privacy Practices.

When your health information is disclosed under this authorization, the recipient has not duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient