SOUTHWEST EYE CARE

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: Date of Birth:

Other Name(s) (i.e. maiden name):

Patient Address:

Patient Phone: Patient Email:

RELEASE RECORDS TO:

Address:

Phone: FAX:

RELEASE RECORDS FROM:

Address:

Phone: FAX:

I authorize the medical office of doctor 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 medical health services) under the following terms and conditions:

1. Detailed description of the information to be release.
2. To whom may the information be release (names(s) or class(es) of recipients).
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual).
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. We cannot refuse to treat you if you chose 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.
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 Signature:

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: