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**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize East Main Vision Clinic 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.

**TO WHOM THE INFORMATION MAY BE RELEASED:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- \_\_\_ Copy of medical records
- \_\_\_ Copy of contact lens prescription
- \_\_\_ Copy of spectacle lens prescription
- \_\_\_ Vision information required by Department of Licensing
- \_\_\_ Pertinent vision information for school activities
  
- \_\_\_ Health information regarding work related injuries
- \_\_\_ Health information required by non-health-plan ins policy (e.g., accident, disability, liability, or auto ins)
- \_\_\_ Other (specify) \_\_\_\_\_

**PURPOSE OF INFORMATION TO BE RELEASED:**

- \_\_\_ At my request
- \_\_\_ To provide information to Department of Licensing
- \_\_\_ To provide information to school
- \_\_\_ To support claims and/or provide reports regarding work-related injuries
- \_\_\_ To support claims and/or provide reports regarding activities covered under non-health-plan ins policy (e.g., accident, disability, liability, or automobile ins)
- \_\_\_ Other (specify) \_\_\_\_\_

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**EXPIRATION DATE (90 days from below signature date unless otherwise specified):**

East Main Vision Clinic will not intentionally release health information identifying you for marketing purposes.

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, 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 a written or electronic note to this office 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.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian)