Drs. Hawks, Besler & Rogers
OPTOMETRISTS
Terry F. Hawks, O.D. **L. Gregory Besler**, O.D. **Jason B. Rogers**, O.D. **Jon B. Stoppel**, O.D.

Date:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECT HEALTH INFORMATION

I authorize the professional office of my optometrist named above to release or obtain 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: **RELEASE / OBTAIN** (circle one)

1. Detailed description of the information to be released:
2. To whom may the information be released (names(s) or class(es) of recipients):

   Name:_____ Phone/Fax: _____

   Address: _____

3. This authorization is being made voluntarily and at my request.

   Patient Name:_____

   Patient Date of Birth:_____

   Patient Address: _____

   Patient Phone Number: _____

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 us a written or electronic note telling us that your authorization is revoked. Send the note to the attention of **HIPAA DESK**. I understand, unless otherwise revoked, this authorization will expire 365 days from the date entered below.

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's signature: _____ Date: _____

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:

Print Name: _____ Relationship to Patient: _____

Source of Authority: _____