Overlake EyeCare, P.S.
We're Focused On You

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**There may be a $24 charge for copies of your medical record (up to 75 pages) unless your copies are being sent to another physician or healthcare facility.**

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

### Patient Information

Name:_____ Date of birth:_____
Previous Name:_____ SS#/ID#:_____
Address:_____ Phone:_____
City:_____ State:____ Zip:_____ Fax:_____

### Releasing Individual or Group ===> ===> ===> Receiving Individual or Group

Name:_____ Name:_____
Address:_____ Address:_____
City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____ Phone:_____
Fax:_____

I authorize the releasing individual or group listed above to release health information identifying me to the receiving individual or group 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:

[ ] Most recent date of service (no charge).

• Detailed description of the information to be released:
[ ] All eye care information. [ ] Other:_____

• The purpose(s) for the release:
[ ] At the request of the individual. [ ] Other:_____

• Expiration date or event relating to the individual or purpose for the release:
[ ] None. [ ] Other_____

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 this note to the office contact person listed at the top of this form. 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.

**X**_____ _____
Signature of patient or patient's authorized representative 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:

Relationship to Patient:_____ Print Name:_____
Source of Authority: [ ] Parent [ ] Guardian [ ] Power of attorney [ ] Other, must specify:_____