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Eye Health Optometry

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RECORD RELEASE FORM

Patient Name: _____ **DOB:** _____/_____/_____

Request Date: _____/_____/_____

I _____(patient) hereby authorize the release of my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the office of Eye Health Optometry, please remit expediently.

Medical Information Requested:

☐ Prescription

☐ Invoiced Receipt

☐ Other _____

_____ _____

(Signature) of Patient or Legal Guardian Date

_____

(Print) Patient or Legal Guardian

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.