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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ______________________________ **Birthdate:** ______________

Every section of this form must be completed in order for this Authorization to be valid.

1. Description of information to be used or disclosed (list specific information being requested - ex. Discharge Summary, Operative Report, History & Physical, Records related to a specific condition or specific time frame):

All Records and Information

2. Records/Information from: Advanced Eyecare Professionals, P.C.

3. Release information to: (ie: Family member who would pick-up glasses/contacts or receive information about your appointment)

Name: ______________________________

Relationship: ______________________________

Phone number: ______________________________

4. Reason for the request (If the patient initiates this Authorization and does not, or elects not to list a purpose, "at the request of the individual" is a sufficient description):

At the Request of the Individual

5. Expiration Date or Event: Until Revoked

I understand that the information being used or disclosed may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS and ARC. I also understand that I have the right to revoke this Authorization by completing a Revocation of Authorization Form.

I further understand that the PHI that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my PHI. In addition, Advanced Eyecare Professionals, P.C. will not condition treatment if this Authorization is not signed, except if: 1) the treatment is related to research, or 2) the provision of health care is solely for the purpose of creating PHI so it can be disclosed to a third party.

By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my PHI in accordance with the terms of this Authorization.

X______________________________ ______________________________
Signature of Patient or Authorized Representative **Date**

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Description of Authorized Representative's printed authority to sign for the patient