Authorization to Request/Disclose Protected Health Information

Renewal OPTOMETRY, LLC

Section A: Patient Information

Patient Name:_____ Patient Date of Birth: _____
Contact Phone Number: _____ Contact Email: _____
Social Security # (Last 4): _____
Patient Address: _____
_____

Section B: Recipient/Provider Information

I authorize _____ to:

___ Release the information indicated to:
___ Request the information indicated from:

Name: _____ Phone: _____
Address: _____ Fax: _____
_____ Email: _____

Section C: Information to be Released/Disclosed

Office/Facility: _____
Dates of Treatment Requested: _____
Records Requested:
_____
_____
_____

Section D: Purpose

__ Medical Follow-Up
__ Attorney
__ Personal Use
__ Disability
__ Insurance
__ Transfer of Care

Section E: Provide Record by Means of:

__ Fax
__ Mail
__ Email
__ Pick-Up

Section F: Attestation

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that this disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.

I understand treatment will still be provided to me if I do not sign this form.

Patient/Authorized Representative Signature: _____
Patient/Authorized Representative Print Name: _____
Relationship to Patient: _____
Date: _____