CONTACT LENS associates

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HIPAA MEDICAL RELEASE AUTHORIZATION FORM

Patient name: _____ Date of Birth: _____

Patient phone number _____

I, _____, hereby authorize _____

(Name of entity disclosing information)

to disclose the following protected health information to: _____

1. Expiration date for the release of protected health information: _____
2. Describe the information to be disclosed (i.e., all medical records, records pertaining to a specific event or condition): _____
3. The purpose(s) for the release (if the authorization is requested by the patient, it is permissible to state "at the request of the patient" as the purpose of release of protected health information: _____

_____

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to one of the HIPAA officers listed at the bottom 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 UNDERSTANDTHIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: _____ Patient signature: _____

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: _____

Fax 505-881-8931

HIPAA Officer: James Britton

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