AUTHORIZATION FOR RECORDS RELEASE REQUEST

Doctor Name: _____

Practice Name: _____

Address _____

Phone / Fax Number _____

Your former patient has consulted Valley Vision Clinic. In order to provide the best possible healthcare, we would like to review the patient's records and history. Thank you in advance for helping us provide continuing quality patient care.

Patient name _____ Date of Birth _____

Last 4-Digits of Social Security Number_____

1. Description of the information to be released:

_____ All information contained in the patient's file, including copies of medical records and copies of records received from any other person or firm with respect to the exam, treatment and care.

_____ Other: _____

2. To whom may the information be released to:

[ ] Luther Ness, O.D. [ ] Angela Ferguson, O.D. [ ] Jeremy Beam, O.D.

[ ] Dennis Poffenroth, O.D. [ ] Richard Harrison, O.D. [ ] Justin Dalke, O.D.

3. Purpose of the release: _____

4. Date of request _____

April 2003, a new law took affect that created a nationwide standard for protecting personal health information. That law is commonly known as HIPAA. The HIPAA privacy regulations apply to everyone with access to personal medical information.

I understand that the information used or disclosed may no longer be protected under HIPAA. At Valley Vision Clinic, we are committed to treating and using protected health information about you responsibly. We respect our legal obligation to keep health information that identifies you confidential and will follow the HIPAA regulations regarding this new requested information.

I have read and understand this form. I authorize the disclosure of my health information as described in this form. This authorization is valid for 90 days unless revoked in writing. I also have the right to revoke my authorization at any time and upon written notification.

Signature:_____ Date:_____
(Patient / Guardian / Legal Representative)

Relationship to patient:_____

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