Patient Authorization to Disclose Protected Health Information

Patient Name	**Date of Birth**	**Last 4 of SSN**
Address	**City,State, Zip Code**	**Telephone #**

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by:	Release to:
Family Vision Optometric Center 4601 Telephone Road, Suite 109 Ventura, CA 93003 (phone) 805-642-4185 (fax) 805-642-4416 OR _____ Organization _____ Address _____ City, State, Zip Code	_____ Organization, Agency, Individual _____ Address _____ Phone _____ City, State, Zip Code _____ Fax
Type of Disclosure Authorized & Delivery Instructions: ☐ Provide copies of records to organization/agency/individual ☐ Mail records directly to address above ☐ Call to pick-up records:_____ ☐ Fax records to:_____	**Pertinent Protected Health Information Allowed to be Included:** ☐ Eyeglass and contact lens prescription ☐ Last 2 years of medical records

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here:_____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving but not limited to:
□ Drug abuse □ Alcoholism □ Sexually transmitted diseases □ Psychiatric conditions □ Sickle cell anemia

SIGNATURE:_____ **DATE:**_____
Patient (Parent or Legal Guardian)

Relationship (if other than patient): _____

*Name of individual signing on behalf of patient:*_____

Verification: Drivers License # _____Other Appropriate ID:_____

OFFICE USE ONLY: Attach copies of required identification.
Number of pages released: _____ Completion date: Delivery method:_____
Name of individual who received request:_____
Date received:_____