ADVANCED
EYECARE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:___________________________________ Date of Birth:________________

Patient Phone:________________________

Release health information to:

Name of patient, provider, or facility:____

Street address, City, State, Zip:____

Fax Number:__________________________ Phone Number:____________________________

I hereby authorize Advanced Eyecare to send the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. I hereby release Advanced Eyecare and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature. When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

☐ I HAVE READ AND UNDERSTAND THIS FORM.

Patient Signature:___________________________________ Date:_________________

If you are signing as a legal representative of the patient, please indicate your relationship.