AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name/DOB ____

Patient Address ____

Patient Phone Number ____

I authorize ______________________________________ to release the following health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS).

Information To Be Released: ☐Health Records ☐Glasses Prescription ☐Contact Lens Prescription

Information Released To: ☐Self ☐Parent/Guardian ☐Other__________________________

Fax number or email address records will be sent to. If other, please specify:

____

I have read and understand this form. I voluntarily authorize this disclosure of my health information as described in this form.

____

Patient Signature Date

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

____

Representative Relationship to Patient

This release expires 90 days after the signature date.

INTERNAL USE ONLY:

Patient ID # ____________