

Lifetime Eye Care
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Print Patient Name: _____

DOB: _____

Requesting Records From:

Dr./Clinic: _____
Address: _____
City, State, Zip _____
Phone#: _____
Fax#: _____

REQUESTING

- | | |
|-----------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Glasses Rx | <input type="checkbox"/> Contact Lens Rx |
| <input type="checkbox"/> Last Exam | <input type="checkbox"/> Treatment Notes |
| <input type="checkbox"/> All records last 3 years | |
| <input type="checkbox"/> Include HIV/AIDS related records | |
| <input type="checkbox"/> Drug/alcohol related records | |

Sending Records To:

Dr./Clinic: _____
Address: _____
City, State, Zip _____
Phone#: _____
Fax#: _____

I hereby authorize the professional office of my doctor named above to **release health information or receive health information** identifying me or my child (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

If you sign this authorization, you can revoke it at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, please send us a written or electronic note telling us that your authorization is revoked. This authorization will expire on the earlier of _____ (date) 180 days from the date of signing or the end of the period reasonably needed to complete the disclosure for the above-described purpose

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

****Restrictions-Initial and complete if applicable:**

_____ This authorization is limited to the following time period _____
_____ This authorization is limited to the following treatment: _____

Patient/Parent Signature: _____ Date of authorization: _____